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MEDICAL ASSOCIATION

Vol. 60 No. 1

97th Annual Meeting, The Greenbrier, August 20-22, 1964

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PARKE-DAVIS

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JANUARY
1964

Vol. 60 No. 1

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston, W. Va. 25324

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Member 1964

CONTENTS

Scientific Articles

Changing Concepts in Surgical Treatment of Duodenal Ulcer—Edward S. Judd, M. D. 1

The Diagnosis and Treatment of Histaminic Cephalalgia—Robert E. Ryan, M. D. 5

Special Articles

Recent Developments in The Federal Government's Narcotic Program—Charles E. Goshen, M. D. 9

A Dire Necessity for West Virginia: 'Adequate Minimum Medical Care'—George R. Callender, Jr., M. D. 14

The President's Page

The Positive Approach of the Medical Profession—Charles L. Goodhand, M. D., President, West Virginia State Medical Association 18

Editorial

Alexis St. Martin Commemorated 19

General News

Proceedings of AMA Clinical Meeting 21
Dr. A. C. Esposito Honored 23
Statement on H.R. 3920 24
Commission on Postmortem Examinations 25
Dr. Earl L. Fisher on Rural Health Program 26
Tuberculosis Deaths Climb 27

Special Departments

WVU Medical Center News xxviii
The Month in Washington xxx
Obituaries xxxi
County Societies xxxii
Woman's Auxiliary xxxv
Book Reviews xxxix
Directory of Physicians in Limited Practice xliii
Index to Advertisers xliv

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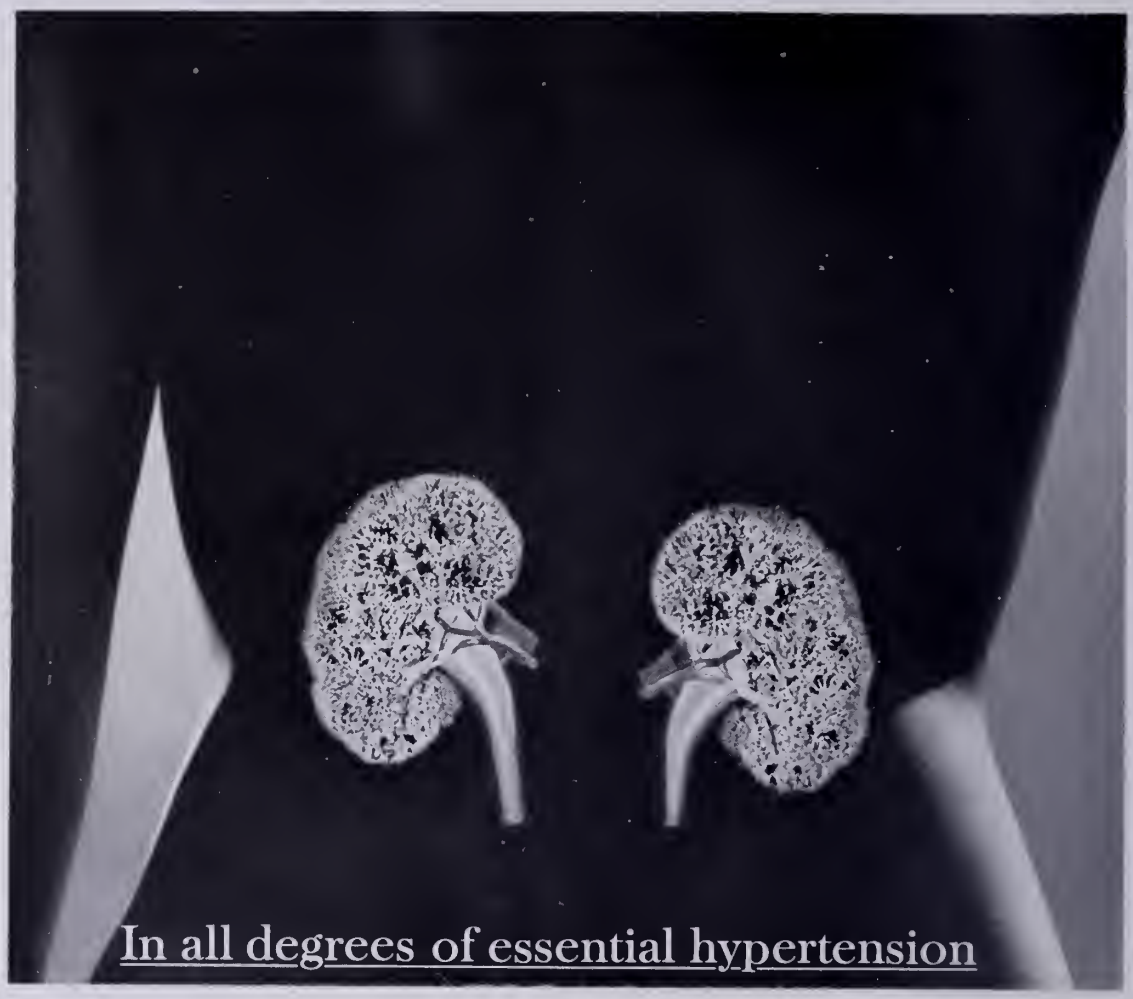

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References: (1) Moyer, J. H., and Heider, C.: Am. J. Cardiol. *9*:920 (June) 1962. (2) Brest, A. N., and Moyer, J. H.: Pennsylvania M. J. *63*:545 (Apr.) 1960. (3) Berry, R. L., and Bray, H. P.: J. Am. Geriatrics Soc. *10*:516 (June) 1962. (4) Hutchison, J. C.: Current Therap. Res. *4*:610 (Dec.) 1962. (5) Feldman, L. H.: North Carolina M. J.: *23*:248 (June) 1962.

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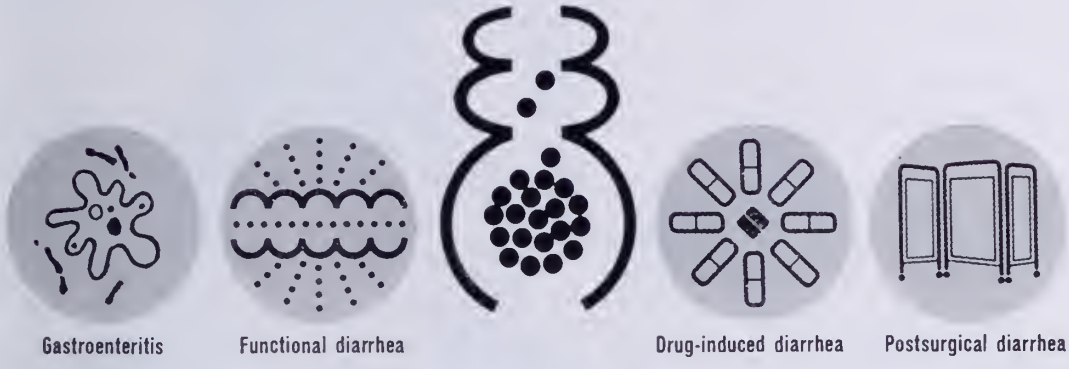

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Research in the Service of Medicine SEARLE

WVU Medical Center
—News—

A new book by Dr. Edward J. Van Liere, Dean Emeritus of the West Virginia University School of Medicine, and Dr. J. Clifford Stickney, Professor of Physiology, was recently published by the University of Chicago Press.

The new book titled "Hypoxia,"* replaces another written earlier by Doctor Van Liere on "Anoxia: Its Effect on the Body," dealing with biomedical problems of flight.

Hypoxia, or oxygen deficiency, is a condition caused not only by high altitudes, but by diseases of the blood, lungs, heart and circulation. One of the biological problems involved in current space explorations by man, hypoxia has been the object of intense research in recent years. The object is to anticipate and solve a medical problem that astronauts will encounter in long space flights.

Drs. Van Liere and Stickney have collaborated on hypoxia research at WVU since 1940. Using mice, rats, guinea pigs, cats, dogs, goats and sheep, they have studied the effects of oxygen-want on the heart, lungs, liver, spleen and other organs at simulated altitudes of up to 70,000 feet.

Assistant Professor of Pathology Named

Dr. Vincente Anido was recently appointed an Assistant Professor of Pathology and Assistant Director of Clinical Laboratories at the WVU School of Medicine.

Doctor Anido is a native of Coruna, Spain, and joined the WVU staff after serving as a research chemist in chemical enzymology with the Dade Reagents, Inc., of Miami, Florida.

He received his M. D. degree from the Havana University School of Medicine where he studied parasitology, tropical medicine and clinical pathology.

Doctor Anido taught clinical pathology at Havana University, 1948-1956, and was professor of Clinical Pathology in the Postgraduate School of the Cuban Medical Association, 1956-59.

New Type Heart Disease Reported

Clinical research at the WVU School of Medicine has led to classification of a disease that can leave a part of the hearts of children muscle bound.

In essence, the discovery is of a muscle mass, heretofore not recognized in diagnosis or reported in scientific literature, that causes the right side of the heart to function inadequately.

*A review on "Hypoxia" will be carried in a future edition of The Journal.

• **Compiled from material furnished by Howard Lewis, Administrative Assistant to the Vice President, West Virginia University Medical Center, Morgantown, West Virginia.**

This finding was described by four members of the School of Medicine Faculty in a paper presented before the recent American Heart Association meeting in Los Angeles.

As a result of this congenital defect, the muscle bound right side of the heart is unable to accept all of the impure venous blood returning from the body—and moreover has difficulty pumping blood it does receive into the lung for purification. All of the children treated with this heart problem were unable to play normally and some had severe heart failure.

Authors of the paper are Drs. Russell V. Lucas, Jr., Assistant Professor of Pediatrics, Robert J. Marshall, Professor of Medicine, David Z. Morgan, Instructor in Medicine, and Herbert E. Warden, Professor of Surgery.

Doctor Lucas presented the paper which was based on diagnostic and surgical findings in eight heart patients at the WVU Hospital. Heretofore, the muscle bound heart had not been recognized because, during surgery when the heart was relaxed, the muscle bundles did not show up. But in the working heart, these muscle bands are evident and profoundly affect blood flow. These changes were demonstrated in six patients using cineangiography.

The muscle bundles showed up even more clearly after patients were asked to exercise and after drugs designed to make the heart beat faster were used.

Librarian Consultant in Far East

Alderson Fry, Librarian of the WVU Medical Center, recently received a Rockefeller Foundation grant for a two-month consulting trip to the Far East.

Mr. Fry will return to Morgantown in mid-January after helping to plan medical center libraries in Bombay, India, and Bangkok, Thailand. He was scheduled to spend three weeks in each city.

Other consulting visits also were planned to medical libraries in the Far East cities of Tokyo and Osaka in Japan; the Philippines; Kuala Lumpur, Malaya; and New Delhi, India.

A native of Fayette County, Mr. Fry joined the WVU staff in 1954. He holds four academic degrees from Marshall University, George Peabody College for Teachers and Vanderbilt University.

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The Month in Washington

• From the Washington Office of the American Medical Association.

Both sides squared off for a new legislative battle this session of Congress on the issue of financing a medical-hospital plan for the aged through higher social security taxes.

There was no vote on the disputed King-Anderson bill (H.R. 3920) in Congress last year. The House Ways and Means Committee held five of a scheduled nine days of hearings on the bill in November, but broke the hearings off on news of the assassination of President Kennedy. The sessions are scheduled to be concluded in January.

The financial soundness of the administration's bill was challenged by Ways and Means Committee Chairman Wilbur Mills (D., Ark.). He told Administration witnesses that if Congress had approved similar legislation in the past, it apparently now would have to increase the Social Security tax almost 100 per cent to maintain the actuarial balance of the Social Security system.

Congress Must Face Up To Costs

Mills said the quarrel he has with the proposed increased tax in the bill is that it does not take into account future costs and the effect they would have on the fiscal soundness of the overall Social Security System. He said a bill should not give the impression that the aged can get these services at some cut-rate cost, or that the economy and costs will remain static.

"If that is a realistic assumption, then I do not know what an unreal assumption is," said Mills. If such a program is passed, he continued, Congress must face up to the costs and provide a tax in existing law that will take into account future costs. If the King-Anderson bill were enacted with a shaky actuarial basis, Mills said, action by some future Congress would be necessary to raise the taxes to support it, and this might be very difficult. Mills has introduced a bill to increase the regular Social Security tax and the wage base it is levied on so the system will be financially in order.

HEW Secretary Anthony Celebrezze told the committee that congressional enactment of the Administration's plan for a hospital-medical benefit program financed by higher Social Security taxes is both "necessary and urgent."

Mundt Attacks HEW Officials

Another major development at the hearings was an attack by Sen. Karl Mundt (R., S.D.) on HEW officials for trying to impede the Kerr-Mills program of federal-state aid for the indigent and medically-indigent elderly.

Mundt declared that Kerr-Mills is the victim of a planned program of interference on the part of the Department of HEW, King-Anderson supporters in Congress, and welfare workers and officials at the state and county levels. He suggested the HEW actions ran counter to the intent of Congress and might be illegal.

The president of the American Medical Association told the Committee that the Administration-backed health care for the aged plan would cost the nation's workers twice as much to start as sponsors of the proposal have claimed or would require periodic tax increases to keep it solvent.

Dr. Edward R. Annis, Miami surgeon, pointed out that previous testimony disclosed that payroll taxes would have to be increased by 1 per cent, half paid by the workers and half by their employers, and the taxable wage base increased to $5,200 to start the program off on a financially sound basis, or periodic tax increases would be required to keep it out of financial trouble.

Acknowledge Need for More Money

The King-Anderson bill (H.R. 3920) calls for a one-half per cent payroll tax increase on workers and employers (one-fourth of one per cent on each) and an increase in the taxable wage base from the present $4,800 to $5,200 to finance a proposed program of hospitalization, nursing home care and related services to everyone age 65 and over.

Doctor Annis said the King-Anderson bill "would transfer to the federal government at a single stroke the responsibility for the purchase of specified hospital and related benefits for all persons over 65, regardless of their desires or their economic need."

"There is no justification," he said, "for the use of tax funds collected from workers at the low end of the income scale to pay these expenses for the entire elderly population, including the self-supporting and the wealthy."

Doctor Annis declared that actuaries of the Department of Health, Education and Welfare had previously acknowledged in a study of the King-Anderson bill that "periodic tax increases will be necessary in a rising economy to keep the program solvent."

Obituaries

AUGUST MILTON FRENCH, M. D.

Dr. August Milton French, 61, of Logan, died on December 10 at a hospital in that city after an extended illness.

Doctor French was a native of Lawrence County, Kentucky, and graduated from Kentucky Normal College. He received his M. D. degree in 1927 from the University of Louisville School of Medicine. He served an internship and residency in surgery at the Louisville City Hospital, 1927-32, and practiced his specialty of general surgery at Louisa, Kentucky, before moving to Logan 26 years ago.

During World War II Doctor French served in the Medical Corps of the United States Navy and was released in 1945 with the rank of Captain.

He was a member of the Logan County Medical Society, West Virginia State Medical Association and American Medical Association. He is survived by his widow.

* * * *

THOMAS FRANKLIN GARRETT, M. D.

Dr. Thomas Franklin Garrett, 73, of Sprague, Raleigh County, died at his home there on December 15.

Doctor Garrett, a native of Saluda, Virginia, received his M. D. degree in 1914 from the Medical College of Virginia and was licensed to practice in West Virginia the following year.

He was an honorary life member of the Raleigh County Medical Society, West Virginia State Medical Association and American Medical Association.

He is survived by two daughters, Mrs. Betty McNew of Charleston and Miss Marie Garrett of Huntington; and four sisters, Mrs. D. W. Moore, Mrs. C. W. Harris and Mrs. Ruth Walden, all of Saluda, Virginia, and Mrs. H. R. Dudley of Norfolk, Virginia.

C. Judson Pearson Appointed

Mr. C. Judson Pearson, former West Virginia Insurance Commissioner, recently was named assistant to Mr. John Hart, managing director of the Blue Cross Hospital Service, Inc., of Charleston.

Mr. Pearson served as assistant counsel of The Equitable Life Assurance Society of the United States in New York City before returning to West Virginia.

PG Course in Georgia

An intensive five-day postgraduate course on "Hypertension and its Complications" will be presented at the Medical College of Georgia in Augusta, February 10-14.

The course is co-sponsored by the American College of Physicians. The fee for ACP members is $60 and $100 for non-members. Further information may be obtained by writing Dr. Edward C. Rosenow, Jr., American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

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County Societies

BARBOUR-RANDOLPH-TUCKER

Dr. Barbara Jones of Morgantown was the guest speaker at the regular monthly meeting of the Barbour-Randolph-Tucker Medical Society, which was held at Hinebaugh's Restaurant in Parsons on October 17.

Doctor Jones, who is Assistant Professor of Pediatrics at the West Virginia University School of Medicine, presented an interesting paper on "The Role of Chemotherapy in Management of Childhood Malignancies."

Doctor Jones discussed the use of steroids, antifalates, alkycating agents and other chemotherapeutic agents in the treatment of various malignancies encountered in childhood and their role as adjuncts to surgery and irradiation. Five-year survival statistics were given for the various forms of treatment.

During the business meeting, Dr. Charles L. Leonard discussed legislation of interest to the medical profession. Seventeen members and their guests attended the meeting.—A. Kyle Bush, M. D., Secretary.

CABELL

Dr. David Z. Morgan of Morgantown was the guest speaker at the regular monthly meeting of the Cabell County Medical Society which was held at the Hotel Frederick in Huntington on November 14.

Doctor Morgan, Instructor in Medicine at the West Virginia University School of Medicine and Medical Director of its Outpatient Clinic, presented a paper on "The Aortagram As It Pertains to Renal Hypertension." He was introduced by Dr. D. Sheffer Clark.

Dr. Jack Leckie, the president, presided at the business meeting and congratulated Dr. John M. Bobbitt for the successful United Fund Campaign in which Cabell County physicians exceeded their quota.—C. H. Boso, M. D., Acting Secretary.

* * * *

HARRISON

Dr. E. F. Heiskell, Jr., of Morgantown, was the guest speaker at the regular monthly meeting of the Harrison County Medical Society which was held at the Stonewall Jackson Hotel in Clarksburg on December 5.

Doctor Heiskell, Clinical Assistant Professor of Surgery at the West Virginia University School of Medicine, presented a paper on "Tetanus: Its Prevention and Treatment." He was introduced by Dr. Lawrence B. Thrush.

Dr. Robert S. Wilson, the president, presided over the business meeting.

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KANAWHA

Dr. George L. Grubb of Charleston was elected president of the Kanawha Medical Society at its regular monthly meeting which was held at the Daniel Boone Hotel in Charleston on December 10. He succeeds Dr. Kenneth G. MacDonald.

Other officers elected to serve during 1964 were as follows:

Dr. Edward Jackson of St. Albans, vice president; Dr. Henry B. Glass, Jr., secretary-treasurer; and Drs. John B. Markey, Thomas S. Knapp and Grover B. Swoyer, all of Charleston, and Richard C. Wallace of St. Albans, members of the Council.

Drs. Jerill D. Cavender, R. Thomas Linger, Harold Selinger and Carl J. Roncaglione, all of Charleston, were elected members of the Blue Shield Board.

* * * *

MERCER

Dr. Robert W. Neilson was the speaker at the regular monthly meeting of the Mercer County Medical Society which was held at the West Virginian Hotel in Bluefield on October 21. His subject was "Unusual Chest Lesions."

During the business meeting, Dr. Ralph E. Haynes was presented a gift for his efforts as chairman of the Polio Immunization Committee in Mercer County. Dr. N. Allen Dyer presented a report on the hypertensive study which is being carried out in Mercer County.

The following physicians were appointed to serve on the Christmas Banquet Committee: Dr. John H. Sproles, Chairman, and Drs. Hampton St. Clair and Upshur Higginbotham.

The regular monthly meeting of the Mercer County Medical Society was held at the West Virginian Hotel in Bluefield on November 18.

Dr. Alfred Jay Bollet of Charlottesville, Virginia, was the guest speaker. He presented a paper on osteoarthritis.

Dr. James E. McGee, Jr., the president, presided at the business meeting and appointed a nominating committee composed of Drs. W. E. Copenhaver, chairman, Joe E. McCary and Henry F. Warden, Jr.

A special committee also was named to make disposition of funds remaining from the recent Sabin Polio program in Mercer County. The committee is composed of Drs. John J. Mahood, chairman, Ralph E. Haynes, David F. Bell, Jr., L. J. Pace and John I. Markell.—J. Brookins Taylor, M. D., Secretary.

* * * *

MONONGALIA

Dr. A. C. Edmundowicz was the guest speaker at the regular monthly meeting of the Monongalia County Medical Society which was held at the Hotel Morgan on November 5. Doctor Edmundowicz, who is Assistant Professor of Medicine at the West Virginia University

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School of Medicine, presented a paper on "Atrial Septal Defect."

Dr. C. A. Logue, the president, presided at the business meeting. A report was presented concerning the activities of the Society during the week of October 20-26, which was officially designated by Mayor Blissett of Morgantown as Community Health Week.

Drs. Carl E. Johnson, J. C. Pickett and G. R. Maxwell were named to a committee to study the advisability of obtaining a full-time director of the county health department.

Dr. George A. Curry presented a report as Chairman of the "Operation Hometown Committee" and he announced that hearings on the King-Anderson Bill would be held in Washington beginning on November 18. Doctor Curry also discussed the MAA program in Monongalia County.

Dr. William A. Welton, also a member of the faculty at the West Virginia University School of Medicine, was elected to membership in the Society.

The meeting was attended by 34 members, four guest physicians and 20 members of the Monongahela Valley Professional Engineering Society who were invited so that they could get a better insight as to work of the Society—George A. Curry, M. D., Secretary.

* * * *

RALEIGH

Dr. B. B. Richmond was elected president of the Raleigh County Medical Society at its regular monthly meeting which was held at the Beckley VA Hospital on November 21. He succeeds Dr. Preston C. Davis.

Other new officers are as follows: Dr. Warren D. Elliott, president elect; Dr. Richard G. Starr, secretary-treasurer; and Dr. Harry F. Cooper, Board of Censors.

Dr. Harry R. Draper of Philadelphia, Assistant Professor of Psychiatry at Jefferson Medical College, was the guest speaker. Doctor Draper, a native of Rainelle, presented a paper on "The Recognition and Management of the Depressed Patient in Office Practice."

Regional GP Symposium Held In Bluefield on Dec. 5

The Mercer County Medical Society and the West Virginia Chapter of the American Academy of General Practice presented a Regional GP Symposium at the West Virginian Hotel in Bluefield on December 5.

Three physicians from the University of Virginia Hospital in Charlottesville, Virginia, and two members of the faculty of the West Virginia University School of Medicine participated in the program.

The University of Virginia speakers were Drs. John A. Owen, Jr., James C. Respess and Gerald Goldstein. Those from West Virginia were Dr. Herbert E. Warden, Professor of Surgery, and Dr. Russell V. Lucas, Jr., Assistant Professor of Pediatrics.

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GREENBRIER VALLEY

The Woman's Auxiliary to the Greenbrier Valley Medical Society held its regular monthly meeting at O'Neil's Restaurant near White Sulphur Springs on November 20.

Hostesses for the luncheon were Mesdames Eugene J. Morhous, James P. Baker, Harvey A. Martin, Don F. Shreve, Arnold J. Brody and E. L. Crumpacker, all of White Sulphur Springs.

Mrs. Philip W. Oden of Ronceverte, the president, presided at the business meeting. Details of the Nurse Scholarship program were discussed.

* * * *

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liary to the Hancock County Medical Society was held at the home of Dr. and Mrs. Leonard Yurko in Weirton on November 19.

Mrs. T. R. Whitaker, legislative chairman, presented a report on "Operation Hometown," the medical profession's legislative campaign to offset the mounting pressure for King-Anderson legislation in the 88th Congress.

Mrs. Irwin M. Bogarad reported on the 39th Annual Meeting of the Woman's Auxiliary to the State Medical Association which was held at The Greenbrier in White Sulphur Springs, August 22-24.

* * * *

HARRISON

The Bridgeport Men's Chorus presented a program of Christmas favorites at the regular monthly meeting of the Woman's Auxiliary to the Harrison County Medical Society which was held at the Stonewall Jackson Hotel in Clarksburg on December 5.

Mrs. Paul E. Gordon, the president, presided over the business meeting. Mrs. James E. Wilson, Jr., Hospital Aid Chairman, presented a display of toys, games and furniture which were to be given to the pediatric departments of St. Mary's and Union Protestant Hospitals in Clarksburg.

* * * *

KANAWHA

The regular monthly meeting of the Woman's Auxiliary to the Kanawha Medical Society was held at the National Guard Armory in Charleston on November 12.

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Auxiliary members paid tribute to one of its former presidents, the late Mrs. C. E. Copeland, who placed the first outdoor Christmas decorations in Charleston 51 years ago.

Mrs. H. P. Agsten of Lewisburg, daughter of Mrs. Copeland, was present at the meeting and was presented with a certificate showing that a gift had been sent to the AMA-ERF in her mother's name.

Mesdames John W. Hash, O. M. Harper and Jane Cox conducted a workshop in which members were taught the art of making Christmas wreaths and other decorations.

The Auxiliary sponsored Health Career Tours for junior high and high school students in the area. Tours were held on November 16 at three hospitals and were well attended.—Mrs. James H. Walker, Press and Publicity Chairman.

* * * *

MARION

A father-son team spoke on "Changes in Medicine—Something Old, Something New," at the regular monthly meeting of the Woman's Auxiliary to the Marion County Medical Society which was held at the Fairmont Hotel on November 26.

Dr. J. J. Jenkins of Farmington and Dr. J. J. Jenkins, Jr., of Fairmont were introduced by Mrs. Seigle W. Parks, the program chairman.

Mrs. William A. Ehrgott, the president, presided over the business meeting. Mrs. Jack C. Morgan, legislative

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chairman, alerted members to the dangers for the American public in the proposed King-Anderson legislation.

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McDOWELL

Mrs. Pat A. Tuckwiller of Charleston, President of the Woman's Auxiliary to the West Virginia State Medical Association, was the honor guest at the regular monthly meeting of the Woman's Auxiliary to the McDowell County Medical Society which was held at the home of Dr. and Mrs. A. J. Villani in Welch on November 13.

The Auxiliary presented Mrs. Tuckwiller with a gift, the presentation being made by Mrs. F. L. Johnston, the first vice president, who presided in the absence of the president, Mrs. J. Hunter Smith.

It was announced that proceeds from a benefit bridge party which was held in October were earmarked for the Health Career Scholarship Fund and Crippled Children's Fund.

Another guest at the meeting was Mrs. R. V. Shanklin of Bluefield, an honorary member and first president of the McDowell County Medical Auxiliary. Co-hostesses with Mrs. Villani were Mrs. E. D. Gibson and Mrs. R. H. Edwards—Mrs. John H. Murry, Secretary.

★ ★ ★ ★

MERCER

Discussions on water safety and the wisdom of selecting a career in health featured the November meeting of the Woman's Auxiliary to the Mercer County Medical Society which was held at the Princeton Elks Club.

The guest speakers were Mrs. John Magann, chair- of the safety program for the Bluefield Chapter of the American Red Cross, and Mrs. H. K. Jarrell, representing the Mercer County Mental Health Association.

Mrs. J. E. Blaydes, Jr., the president, presided at the business meeting and reports were presented by Mesdames James E. McGee, Jr., R. S. Gatherum, Jr., A. C. Van Reenen and John J. Mahood.

★ ★ ★ ★

MINGO

Mrs. Pat A. Tuckwiller of Charleston, President of the Woman's Auxiliary to the West Virginia State Medical Association, was the guest speaker at the November meeting of the Woman's Auxiliary to the Mingo County Medical Society which was held at the Mountaineer Hotel in Williamson.

Mrs. Robert J. Tchou, the president, extended greetings on behalf of the Mingo County group. Mrs. Tchou also serves as recording secretary of the Woman's Auxiliary to the State Medical Association.

Mrs. John Carl Lawson and Mrs. Frank J. Burian served as hostesses for the luncheon.—Mrs. Frank J. Burian, Secretary.

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Book Reviews

ALCOHOL AND CIVILIZATION.—By Salvatore Pablo Lucia, M. D., SC. D., Professor of Medicine and Preventive Medicine; Chairman of the Department of Preventive Medicine; Lecturer in Medical History and Bibliography; Consulting Physician in Oncology; University of California School of Medicine, San Francisco, California. Pp. 416. McGraw-Hill Book Company, Inc., 330 West 42nd Street, New York, New York. 1963. Price $3.95.

This book consists of a series of lectures and discussions from a symposium arranged by Salvatore Pablo Lucia, M. D., of the Department of Continuing Education in Medicine, University of California School of Medicine, San Francisco. The participants are outstanding Doctors of Medicine, Philosophy, Physiology, Dietetics—authors and judges representing five countries.

As the author states "so intent are we on rooting out this evil" that we are willing to throw out the baby with the bath water. We forget that fermented beverages have been a dietary supplement since the time of most ancient civilization.

The various sections discuss: the effect of alcohol on the body, on the mind, social complications, alcohol in our society, specific and interdisciplinary viewpoints.

The book indicates that in the early medicine of Aesculapius, wine was used to develop the ritualistic sleep. The dreams that occurred during sleep were interpreted by the priests or physicians in what was an early manifestation of analysis. It is stated that the pine resins added to Greek wines, then and now, may have enhanced their medicinal value. To this reviewer they stultify the appetite and taste, as Temple Fielding states, like a mixture of nail polish remover and deck enamel.

There is general discussion of the cocktail party with the conclusion that in the modern party, the purpose of the cocktail as an appetizer is lost or subjected to excess.

There are many interesting and no doubt valid conclusions concerning alcoholism, its cause and cure. The discussion of legal alcoholism is excellent.

The book provides much source material to all physicians and welfare workers interested in an understanding of this major personal and social problem.

The reader is left with the impression that the intake of alcohol, properly diluted and preferably in the nature of wine, is good for the body and soul providing one observes the ancient Greek maxim, "nothing to excess."—George F. Evans, M. D.

★ ★ ★ ★

MENTAL MECHANISMS.—By Henry P. Laughlin, M. D., Practicing Psychiatrist in Bethesda-Chevy Chase, Maryland; Associate Clinical Professor of Psychiatry, George Washington University School of Medicine, Washington, D. C.; Head, Division of Psychiatry, Suburban Hospital, Bethesda, Maryland. Pp. 262. Butterworth Inc., 7235 Wisconsin Avenue, Washington 14, D. C. 1963. Price $7.50.

This book deals with some of the major mechanisms of defense. It is very well organized. It is concise but treats each subject adequately. The author does

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simplify but the reader does not get the feeling he is being "talked down to."

It is an excellent book for the psychiatrist interested in a different approach to the subject. For the general practitioner or specialist in other fields, it is a good basic book for the understanding of dynamic psychiatry and some knowledge of how the economy of the psyche works.—David H. Smith, M. D.

Synthetic happiness is the most expensive.—Arnold H. Glasow.

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WANTED—Physician for chief of outpatient clinic in 200-bed general medical and surgical VA Hospital affiliated with WVU School of Medicine. Salary dependent on qualifications. Many fringe benefits. Apply to Director, VA Hospital, Clarksburg, W. Va.

WANTED—General practitioner in Richwood. Citizens of this community are interested in helping physician and believe that the locality can offer an ambitious doctor many advantages. Contact Sr. M. Pia, C.M.P., Administrator, Sacred Heart Hospital, Richwood, W. Va.

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FEBRUARY
1964

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Member 1964

CONTENTS

Scientific Articles

Treatment of Berry Aneurysms of the Carotids and Their Branches—E. Lyle Gage, M. D. 29

Community Hospital Experience in the Surgical Management of the Elderly Patient—Edward C. Voss, Jr., M. D. 35

Special Articles

Dr. Jesse Bennett—Pioneer Physician (1769-1842)—Mrs. Melinda Hamilton 42

The Matrix of Life—W. D. Snively, M. D. 44

The President's Page

Communication As A Guide to Progress—Charles L. Goodhand, M. D., President, West Virginia State Medical Association 50

Editorial

It Is A Coffin Nail 51
Dr. Jesse Bennett—Pioneer Physician 52
Hyperbaric Oxygenation 52

General News

Winter Meeting of Council 54
Revolving Loan Fund Established 56
WVU President Rural Health Speaker 58
All-Out Effort Against Rheumatic Heart Disease 59

Special Departments

WVU Medical Center News xxvi
The Month in Washington xxviii
Obituaries xxx
County Societies xxxiii
Woman's Auxiliary xxxvii
Directory of Physicians in Limited Practice xlii
Index to Advertisers xlvi

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By H. J. REUTER, M.D., Private Urologic Hospital, Stuttgart, Germany. Translated by HERBERT G. W. FROHMÜLLER, M.D., Fellow in Urology of the Mayo Clinic, Rochester, Minnesota. 114 pages, 6⅝" x 9½", with 178 figures, 105 in color. About $15.00. *New—Just Ready!*

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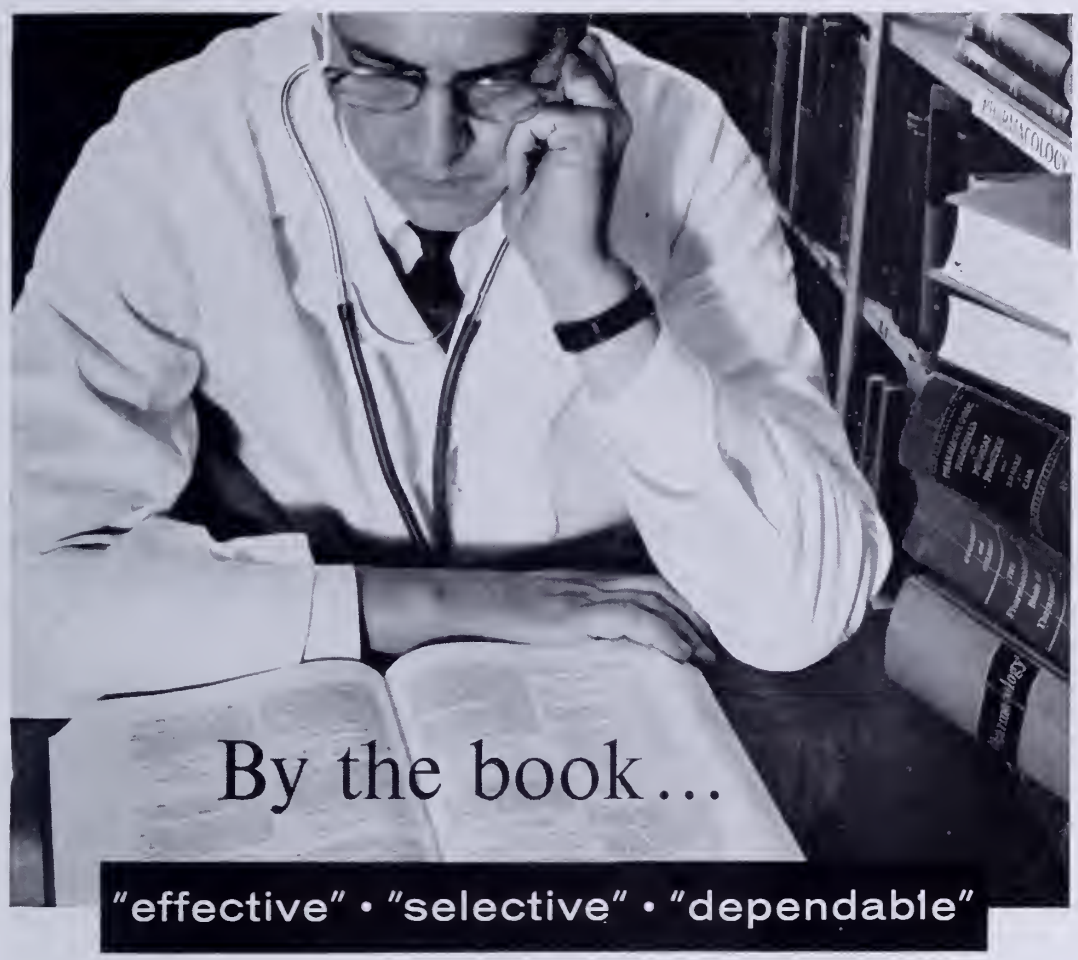

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WVU Medical Center
—News—

• **Compiled from material furnished by Howard Lewis, Administrative Assistant to the Vice President, West Virginia University Medical Center, Morgantown, West Virginia.**

THE number of West Virginians applying for entrance in the first-year class at the West Virginia University School of Medicine next fall has shown an increase over 1963.

Dean Clark K. Sleeth said 279 students had applied with 142 of those applicants residents of West Virginia. Last year, 125 West Virginians applied.

More than 900 out-of-state students sought information on requirements at the WVU School of Medicine and 137 were permitted to make formal application.

The 60-member first-year class, which will begin studies next September, will be filled by mid-February. This will be the fourth full-size class accepted in the four-year program.

Medical Education Directors Meet

Directors of Medical Education from five of the seven West Virginia hospitals with approved internship programs and administrators from three of these hospitals participated in a special program at the School of Medicine, October 31-November 2.

The physicians and administrators were given an opportunity to meet and talk with the medical students from all four classes, particularly the 41 seniors who are scheduled for graduation on June 1. This will be the last of the smaller classes.

Dean Sleeth said the informal program also presented an opportunity for the West Virginia State Medical Association's Sub-Committee on Medical Education to meet and discuss mutual problems of conducting internship and residency programs.

Three PG Programs Draw 173 Physicians

More than 170 physicians participated in postgraduate symposiums on surgical management, pulmonary problems and cardiac disease which were held at the Medical Center in October. In addition, each symposium offered an opportunity for continuing education of medical, nursing and graduate students, University Hospital staff, and basic and clinical sciences faculty.

The registration for the three programs was as follows:

Oct. 4-5—"Symposium on Principles of Surgical Care," sponsored by the School of Medicine and the West Virginia Chapter, American College of Surgeons. Ninety registrants and 200 students and faculty.

Oct. 8-9—"Pulmonary Infections," sponsored by the School of Medicine and the West Virginia Tuberculosis and Health Association. Fifty registrants and 75 students and faculty.

Oct. 17-19—"Centennial Symposium on Cardiac Disease," sponsored by the School of Medicine with partial support through a $500 grant from the West Virginia Heart Association. Thirty-three registrants and 168 students and faculty.

Dean Sleeth said 45 scientific papers were presented during the three programs; 21 by the visiting faculty and 24 by members of the WVU School of Medicine faculty.

Lecture by Air Force Physician

One of the highlights of the Spring lecture program at the School of Medicine will be the appearance on March 13 of Lt. Col. William K. Douglas.

Colonel Douglas, an Air Force officer, has been medical officer for Project Mercury at Cape Kennedy, Florida. He will speak on Space Medicine.

Dr. Sleeth Member of Survey Team

Dr. Clark K. Sleeth, Dean of the WVU School of Medicine, recently served as a consultant to the Inter-Mountain State Survey of Medical Education which was conducted by the Western Interstate Commission on Higher Education (WICHE).

Doctor Sleeth's assignment was to determine the feasibility of starting a new two-year school of medicine in Idaho which would also serve the neighboring states of Montana, Wyoming and Nevada. None of these states has a medical school at the present time.

The selection of Doctor Sleeth as a member of the survey team was because of his long-time association with the two-year School of Medicine at West Virginia University and the similar geographical and recruitment problems in the four western states and West Virginia.

Doctor Sleeth and the president of the University of Vermont spent five days with a full-time study director for the commission. Visits were made to the University of Idaho and Idaho State University during that period.

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The Month in Washington

• From the Washington Office of the American Medical Association.

PROPOSALS to provide limited health care for the aged under social security continue to be the most important legislation before Congress so far as the medical profession is concerned. In his State of the Union message to Congress, President Johnson labeled it "must" legislation and asked for Congressional approval before the end of this summer.

The House Ways and Means Committee late in January wound up hearings on the King-Anderson bill, the Administration's medicare legislation. The hearings had been interrupted by President Kennedy's assassination. The committee—with a majority of its members believed to be still opposed to such legislation—did not indicate immediately when it would act further on the bill.

President Apparently Misinformed

In commenting on the State of the Union message, Dr. Edward R. Annis, President of the American Medical Association said that President Johnson apparently had been grossly misinformed by his advisers on the legislation.

"Medicare would not be an insurance program of health care for the elderly, and workers would not contribute to a fund for their old age," Doctor Annis said. "Medicare would be strictly a tax program, forcing wage earners to pay a substantial increase in their payroll taxes to finance hospitalization for everyone over 65, including those who are wealthy and millions of others who already are protected with hospital insurance.

"The President has also been misinformed on the cost of such a program. Testimony of the Chief Actuary of the Social Security Administration before the Ways and Means Committee in November shows that every worker earning one hundred dollars or more a week would be forced to pay at least 23 per cent more in payroll taxes to finance this inequitable program.

"Medicare is unnecessary. Private health insurance, now protecting more than 10 million elderly, is available to those who can pay their own way, and the Kerr-Mills Law, already enacted in more than 40 states, can help those who need help."

Keogh Amendment Proposed

Other legislative proposals of interest to physicians include:

An amendment to the Keogh law that would remove the present 50 per cent limitation on the amount of income tax deduction a self-employed person can claim on his annual retirement savings. It also removes the $2,500 or 10 per cent of income limitation on the amount of retirement savings an individual with employees could use for tax deduction purposes. This would be a tremendous boost for the Keogh program and for self-employed persons with retirement savings plans. Rep. Eugene Keogh (D., N.Y.) and Sen. George Smathers (D., Fla.) are sponsoring the amendment.

The Internal Revenue Service recently issued a tentative ruling that was a setback to physicians and other professional men planning to band together into corporations for tax purposes. A proposed regulation stated that such professional organizations must have all of the characteristics of a business corporation in order to qualify for corporation tax treatment, which would be virtually impossible for a group of professional men.

The regulation would knock out the so-called Kintner regulations of 1960 under which IRS stated that associations of professional men would be classified for tax purposes as corporations provided certain corporate characteristics were followed and provided that state law authorized establishment of the groups as corporations.

The IRS proposal is not final and will be the subject of hearings at a later date. It appears certain to be the subject of court litigation, if made final.

Other Legislation of Interest

—A Civil Defense bill that has passed the House and is before the Senate. It would provide a $190 million program of grants to hospitals and other non-profit institutions for building fall-out shelters.

—An Administration proposal to require clearance and approval of new medical devices, which means anything from a new type of forceps to the most complicated device. FDA would rule on the efficacy as well as the safety of such devices, as it does now on new drugs.

—"Humane" treatment of laboratory animals. Most of such bills would require research institutions to provide laboratory animal care conforming to certain fixed federal standards in order to qualify for federal grants.

—An amendment to the medical education law that would forgive part of the repayment of federal loans to students if the young physician settles in a physician-shortage area.

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Obituaries

WILLIAM ARTHUR ADAMS, M. D.

Dr. William Arthur Adams, 80, who had practiced medicine for more than 50 years in Parkersburg, died on December 22 at a hospital in that city.

Doctor Adams was a native of Highland, Ritchie County, and was graduated from the old West Virginia Conference Seminary in Buckhannon. He received his M. D. degree in 1909 from the University of Louisville School of Medicine and was licensed to practice in West Virginia that same year.

Doctor Adams was an honorary life member of the Parkersburg Academy of Medicine, West Virginia State Medical Association and American Medical Association.

He is survived by a son, Sterling C. Adams of Farmville, Virginia; two brothers, Dr. Charles T. Adams of Parkersburg, and Russell D. Adams of Vienna; and a sister, Mrs. E. S. Grimm of Parkersburg.

★ ★ ★ ★

ROBERT W. BESS, M. D.

Dr. Robert W. Bess, 66, of Piedmont, died on December 22 at his home in that city.

Doctor Bess, who practiced in Keyser, was born at Hinton on June 5, 1897, the son of the late Charles L. and Mary Napier Bess. He attended the two-year School of Medicine at West Virginia University and received his M. D. degree in 1924 from the Medical College of Virginia.

He served an internship at the Medical College of Virginia Hospitals, 1925-26, and took postgraduate work at the Medical College of Virginia, the Chicago Eye, Ear, Nose and Throat Hospital and the University of Indiana.

Doctor Bess opened his practice in Piedmont in 1926 and the following year joined with his brother, the late Dr. Thomas E. Bess, to purchase the Hoffman Hospital in Keyser. In 1931 they constructed the Potomac Valley Hospital in Keyser.

During World War II he served in the Medical Corps of the United States Army.

Doctor Bess was a member of the Potomac Valley Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by a son, Dr. Robert W. Bess, Jr.; and three daughters, Mrs. Robert Campbell of Edgewood Arsenal, Maryland; Mrs. Robert Keiser of Richmond, Virginia; and Mrs. James Kenny of Westernport, Maryland.

★ ★ ★ ★

GLENN WALTON BREWSTER, M. D.

Dr. Glenn Walton Brewster, 83, of Cincinnati, Ohio, who formerly practiced in Davy, McDowell County, died at his Cincinnati home on December 5, 1963.

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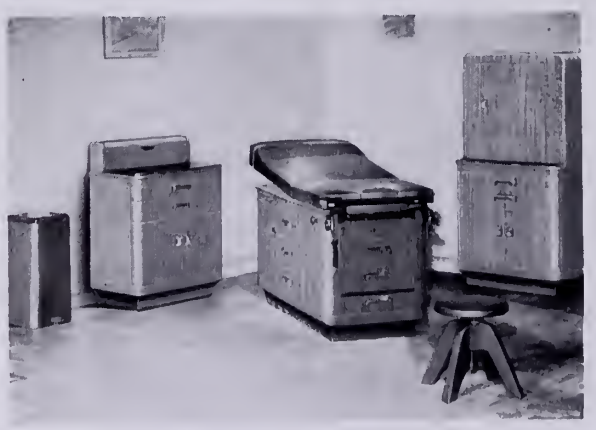

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He was a native of Newhall, McDowell County, attended Tazewell College and received his M. D. degree in 1903 from the University of Louisville School of Medicine.

Besides his widow, he is survived by two daughters, Mrs. Pearl B. Callaway of Cincinnati, and Mrs. A. D. Thomas of Ft. Thomas, Kentucky; and a son, Churchill Brewster of Cincinnati.

* * * *

ALBERT UPDYKE TIECHE, M. D.

Dr. Albert Updyke Tieche, 77, of Beckley, died at his home in that city on January 7. Death was attributed to a heart attack.

Doctor Tieche was born at Point Pleasant, Virginia, on April 22, 1886, the son of Albert Weston and Alice Lee Updyke Tieche.

He attended Cluster Springs Academy in Cluster Springs, Virginia, and received his M. D. degree in 1911 from the Medical College of Virginia. He served an internship at the U. S. Marine and Public Health Hospital in Buffalo, New York, 1911-12, and a residency at the Chesapeake and Ohio Railway Hospital in Huntington, 1912-13, before entering general practice in 1913 at Welch.

He practiced in the McDowell and Raleigh County coalfields until 1922 when he and the late Dr. J. H. McCulloch purchased the Beckley and Oak Hill Hospitals. Doctor Tieche was active in their management until his death.

Doctor Tieche was an honorary life member of the Raleigh County Medical Society, West Virginia State Medical Association and American Medical Association. He also was a member of the Southern Medical Association, American College of Surgeons, International College of Surgeons, Southeastern Surgical Congress and the American Academy of Hospital Administrators.

Besides his widow, he is survived by a son, Albert M. Tieche of Beckley; a daughter, Mrs. Hulett C. Smith of Beckley; and a sister, Mrs. Myrtle Wagner of Staunton, Virginia.

* * * *

HAROLD SINCLAIR TAIT, M. D.

Dr. Harold Sinclair Tait, 74, of Wheeling, former Clinical Director and Superintendent of Weston State Hospital, died on December 22 at his home.

Doctor Tait was a native of St. Johns, Newfoundland, and he received his M. D. degree in 1914 from the Dalhousie University Faculty of Medicine in Halifax, Nova Scotia.

He joined the Weston State Hospital staff as Clinical Director in 1948 and served as Superintendent of the Hospital from 1951 to 1957.

Doctor Tait was a former member of the Ohio County Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by a daughter, Mrs. Dorothy Mills Johnson of Wheeling, and a son, David H. Tait of Greeley, Colorado.

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County Societies

BARBOUR-RANDOLPH-TUCKER

Dr. Charles L. Goodhand of Parkersburg, President of the West Virginia State Medical Association, was the guest speaker at the regular monthly meeting of the Barbour-Randolph-Tucker County Medical Society which was held at the Coach and Four Restaurant in Elkins on November 21.

Doctor Goodhand discussed "Medical Communications," which he said was "the transference of thought and action so that those outside the medical profession might have an understanding of our problems."

He also pointed out the various functions of the State Medical Association and the county societies and urged physicians to participate in community affairs.

Twenty-five members and guests attended the meeting. During the business session, Dr. Vernon E. Duckwall, the president elect, was authorized to appoint a Committee on Medicine and Religion.—A. Kyle Bush, M. D., Secretary.

* * * *

EASTERN PANHANDLE

The Eastern Panhandle Medical Society held its regular monthly meeting at the Shenandoah Hotel in Martinsburg on January 8.

Dr. F. A. Hamilton, Jr., the new president, presided

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G. B. Krivchenia, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

Psychiatry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Nancy Fondriest, M. T.

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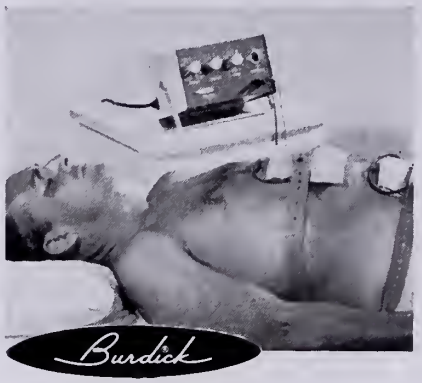

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at the business meeting. Other new officers are Dr. William L. Rodgers, first vice president; Dr. Daniel E. Hendricks, second vice president; and Dr. E. Andrew Zepp, secretary-treasurer.

Dr. N. B. Groves, a member of the Legislative Committee of the State Medical Association, reported on a joint meeting of the Association's Council, Legislative and Public Service Committees in Charleston on January 5.

Doctor Rodgers reported on the mass polio immunization program which is planned in the Spring by the Society in Berkeley, Jefferson and Morgan Counties.

* * * *

HARRISON

Dr. Alvin L. Watne of Morgantown was the guest speaker at the regular monthly meeting of the Harrison County Medical Society which was held at the Stonewall Jackson Hotel in Clarksburg on January 2.

Doctor Watne is Associate Professor of Surgery, Chief of the Cancer Committee and Director of the Tumor Clinics at the West Virginia University School of Medicine.

Dr. Robert S. Wilson, the president, presided at the business meeting. Doctor Watne was introduced by Dr. James A. Thompson.

* * * *

McDOWELL

The regular monthly meeting of the McDowell County Medical Society was held at the Stevens Clinic Hospital in Welch on October 9.

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Dr. Dante Castrodale, the president, presided at the business meeting. Dr. A. J. Villani reported on the Sabin Oral Polio vaccine project which was endorsed by the Society.

Doctor Villani also presented a report on "Operation Hometown," the medical profession's legislative campaign to offset the mounting pressure for King-Anderson legislation in the 88th Congress.—J. Hunter Smith, M. D., Secretary.

* * * *

MERCER

Dr. John J. Mahood of Bluefield was installed as president of the Mercer County Medical Society during the annual Christmas Party which was held at the Bluefield Country Club on December 11. He succeeds Dr. James E. McGee, Jr.

Dr. Sam Milchin was installed as vice president and Dr. J. Brookins Taylor as secretary-treasurer.

* * * *

MINGO

The Mingo County Medical Society held its annual Christmas dinner meeting at the Mountaineer Hotel in Williamson on December 11.

Dr. John Carl Lawson, the president, presided at the meeting which was attended by the members' wives and other guests.

The Rev. William Hunter and Dr. Robert J. Tchou presented entertainment on the piano and clarinet.

Radiology:
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Surgery:
HU C. MYERS, M. D.
A. KYLE BUSH, M. D.

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RAYMOND W. CRONLUND, M. D.

Internal Medicine:
JOHN E. LENOX, M. D.
J. L. RITTMEYER, M. D.
ERNEST G. GUY, M. D.

Pediatrics:
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Dentistry:
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MONONGALIA

Dr. R. F. Krause was elected president of the Monongalia County Medical Society at the regular monthly meeting at the Hotel Morgan in Morgantown on December 3. He succeeds Dr. C. A. Logue.

Dr. George A. Curry was named vice president, Dr. W. E. King, secretary, and Dr. John H. Trotter, treasurer. Dr. D. Franklin Milam was elected a delegate to the annual meeting of the West Virginia State Medical Association at The Greenbrier in August and Drs. Logue and Curry alternate delegates. Doctor Logue also was named to the Board of Censors for a three-year term.

Dr. W. Gene Klingberg presented a report concerning emergency cases in which the patient is not able to give consent for proper surgery or care. It was recommended that steps be taken to seek legislation which would protect physicians in these instances.

Dr. Russell V. Lucas, Jr., Assistant Professor of Pediatrics at the West Virginia University School of Medicine, was unanimously elected to membership in the Society.—George A. Curry, M. D., Secretary.

* * * *

PARKERSBURG ACADEMY

Dr. Charles L. Goodhand of Parkersburg, President of the West Virginia State Medical Association, was the speaker at a joint dinner meeting of the Parkersburg Academy of Medicine and the Woman's Auxiliary which was held at the Chancellor Hotel in Parkersburg on January 9.

Doctor Goodhand, a past president of the Parkersburg Academy, presented an interesting talk on the problems currently facing organized medicine on both the State and national levels.

Another honor guest was Mrs. Pat A. Tuckwiller of Charleston, president of the Woman's Auxiliary to the State Medical Association.

A social hour preceded the dinner meeting and entertainment was provided by students from Parkersburg High School. Dr. Robert C. Lincicome, the president, presided at the meeting and the entertainment program was under the direction of Dr. Richard W. Corbitt.

* * * *

RALEIGH

The annual Christmas Dinner-Dance of the Raleigh County Medical Society was held at the Black Knight Country Club in Beckley on December 13.

The wives of the members of the Society were guests and were welcomed by Dr. Preston C. Davis, immediate past president.

Dr. Davis introduced Dr. Warren D. Elliott, the new vice president, and Dr. Richard G. Starr, the secretary-treasurer. Doctor Elliot read a letter of welcome from Dr. B. B. Richmond, the new president, who was not able to attend.

Mrs. John J. Marra, president of the Woman's Auxiliary, spoke briefly, expressing the group's appreciation and outlining its program.

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to the

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HARRISON

The Woman's Auxiliary to the Harrison County Medical Society held an AMA-ERF dessert and bridge meeting at the home of Dr. and Mrs. Richard V. Lynch, Jr., in Clarksburg on January 9.

Assisting the hostess, Mrs. Lynch, were Mesdames James E. Wilson, Jr., and E. Burl Randolph.

Thirty-seven members attended the meeting with all contributions going toward the AMA-ERF Program which has received more than $1 million from the Woman's Auxiliary to the American Medical Association in the past decade.—Mrs. Karl A. Dillinger, Publicity Chairman.

MARION

The Woman's Auxiliary to the Marion County Medical Society entertained members of the Society with a Christmas Smorgasbord at the Fairmont Hotel in Fairmont on December 8.

More than 50 persons attended the affair. Following the dinner, Mrs. William A. Ehrgott accompanied the group in carol singing which was led by Mrs. Claude S. Lawson, Jr.

The party was planned by the Auxiliary's executive board composed of Mesdames John D. Lindsay, William T. Lawson, Claude S. Lawson, Jr., F. W. Mallamo, Kenneth D. Bailey and William A. Ehrgott.

* * * *

MONONGALIA

The December meeting of the Woman's Auxiliary to the Monongalia County Medical Society was held at the Lakeview Country Club near Morgantown.

Mrs. W. M. Warman served as chairman of the hostess committee. She was assisted by Mesdames James Hugh Wiley, Lawrance S. Miller, David Z. Morgan, Enrico Paparozzi, Edward J. Van Liere, Herbert E. Warden and D. Franklin Milam.—Mrs. John J. Lawless, Publicity Chairman.

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New Saunders Books

W. B. Saunders Company features the following new editions in their full page advertisement appearing on page iii in this issue:

1964 Current Therapy Volume. New. Today's best treatments, ranging from up-dated information on general immunization to newer agents in Rx of meningitis.

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Reuter—"Atlas of Urologic Endoscopy." New. Explains in word and picture precisely how to use the endoscope.

145 Million Americans Protected By Health Insurance

In 1963 the health insurance business helped to protect an estimated 145 million Americans against the costs of their health care, the Health Insurance Institute reported recently in a review of the past year.

The total figure represents an increase of 3.6 million persons over the number protected in 1962, and stands at 77 per cent of the civilian population.

Total benefits paid to insured persons by all insuring organizations over the year were estimated at $7.8 billion, or some $700 million more than were paid out in 1962. The insuring organizations include 879 insurance companies, 77 Blue Cross and 71 Blue Shield plans, and nearly 800 other health care plans.

The Institute said that new records were established in five types of basic health insurance coverages—hospital, surgical, regular medical, major medical, and loss of income—as well as in the respective amounts of benefits paid to insured persons.

Of the 145 million persons protected against hospital expenses, an estimated 135 million persons also had surgical expense insurance and 101 million had regular medical coverage in 1963. The increase over the 1962 totals for surgical and regular medical insurance was 3.8 million and 2.8 million persons respectively.

Insurance companies paid more than $4.1 billion of the 1963 benefits, an increase of about nine per cent over the 1962 total of $3.8 billion. All other insuring organizations accounted for nearly $3.7 billion in benefits in 1963 for a 10 per cent increase over the 1962 benefit total of $3.3 billion.

Major medical expense insurance issued by insurance companies continued to be the fastest growing of all health insurance programs. An estimated 41.5 million persons were protected against the costs of serious illness or injury in 1963. That's an increase of 3.8 million persons over 1962, or an 8.4 per cent rise. Comparable percentage increases include a 2.5 per cent rise over 1962 for hospital expense insurance, and a 2.9 per cent rise each for surgical expense insurance and regular medical expense insurance. Major medical programs, introduced nationally in 1951, are issued by companies on group, individual, and family insurance plans.

AMA To Award $5,000 Annually For Outstanding Reporting

The American Medical Association has announced a $5,000 medical journalism awards program "to recognize journalism that contributes to a better public understanding of medicine and health in the United States." Awards of $1,000 each will be presented for outstanding reporting on health and medicine in five categories—newspapers, magazines, radio, television, and in newspaper editorial writing.

The awards are intended for recognition of outstanding reporting of the scientific and clinical aspects of medicine and will be presented for the first time in 1965, based on work published or broadcast during the calendar year of 1964.

Entries may be sent to the 1964 Medical Journalism Awards Committee, American Medical Association, 535 N. Dearborn St., Chicago, Ill. Deadline is Feb. 1, 1965, although entries may be submitted at any time prior to that date.

Newspaper and magazine articles should be submitted in triplicate, validating date of publication and showing the material as it was presented to the public. Entries for radio or television should consist of three copies of the complete script and a 200-word summary of the script, together with film or kinescope of television entries and audio tape or transcription of radio entries. Entrants may make as many entries as they wish.

Each entry should be accompanied by a statement listing title of entry, writer or producer, publication in which the article appeared or station or network over which program was broadcast, date entry was published or broadcast, category for which entry is submitted, name, address and title of person submitting entry. Radio and television films, tapes or kinescopes will be returned if requested.

Categories of competition are:

(1) Newspapers—For a distinguished example of a news or feature story or series in a United States newspaper of general circulation published daily, Sunday or at least once a week.

(2) Magazines—For a distinguished example of an article or series in a United States magazine of general circulation published weekly, monthly, quarterly or at other regular intervals.

(3) Editorial—For a distinguished example of editorial writing in a United States newspaper of general circulation published daily, Sunday or at least once a week.

(4) Radio—For a distinguished example of reporting on medicine or health on a United States radio station or network.

(5) Television—For a distinguished example of reporting on medicine or health on a United States television station or network.

The awards will *not* be given for work, however excellent, that involves primarily the relaying of medical knowledge to the medical profession and to allied professions. Members of the medical profession, medical associations and their employees are not eligible to submit entries.

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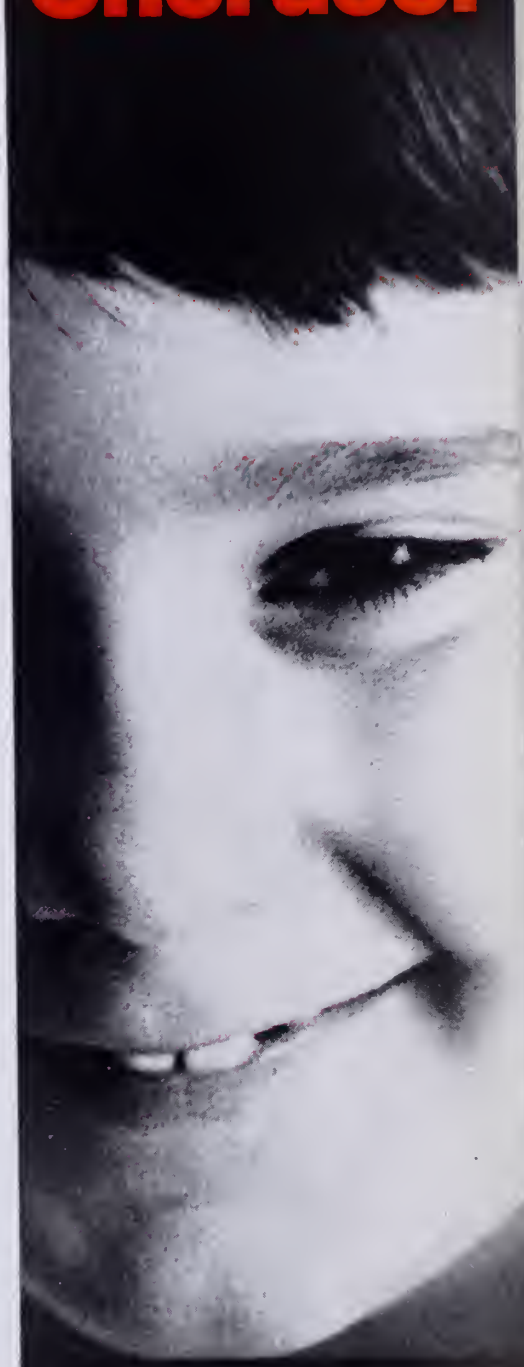

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Society	President		Secretary		Meetings
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Boone	A. E. Glover	Madison	Harold H. Howell	Madison	2nd Wed.
Brooke	W. T. Booher, Jr.	Wellsburg	W. T. Booher, Sr.	Wellsburg	
Cabell	Clarence H. Boso	Huntington	W. L. Neal	Huntington	2nd Thurs.
Central West Virginia	Donald S. Groves	Summersville	R. L. Chamberlain	Buckhannon	As Scheduled
Eastern Panhandle	F. A. Hamilton, Jr.	Martinsburg	E. Andrew Zepp	Martinsburg	2nd Wed.
Fayette	Chuan H. Lee	Montgomery	D. Alene Blake	Oak Hill	1st Wed.
Greenbrier Valley	Harvey A. Martin	White Sul. Spgs.	Stuart T. Bray	White Sul. Spgs.	2nd Wed
Hancock	David H. Williams	Weirton	Ray S. Greco	Weirton	2nd Tues.
Harrison	Robert S. Wilson	Clarksburg	Richard K. Hanifan	Clarksburg	1st Thurs.
Kanawha	George L. Grubb	Charleston	Henry R. Glass, Jr.	Charleston	2nd Tues.
Logan	George R. Mullins	Logan	Thomas P. Long	Man	2nd Wed
Marion	James E. Wotring	Fairview	G. Thomas Evans	Fairmont	Last Tues.
Marshall	Kenneth J. Allen	Moundsville	J. W. Myers	Moundsville	Semi-Ann.
Mason	C. Leonard Brown	Pt. Pleasant	Richard L. Slack	Pt. Pleasant	Bi-Monthly
McDowell	John S. Cook	Welch	David J. Skewes	Coalwood	2nd Wed.
Mercer	John J. Mahood	Bluefield	J. Brookins Taylor	Bluefield	3rd Mon.
Mingo	Andrew H. Henderson	Williamson	Russell A. Salton	Williamson	2nd Wed.
Monongalia	Reginald Krause	Morgantown	W. E. King	Morgantown	1st Tues.
Ohio	Joseph L. Curry	Wheeling	A. J. Purpura	Wheeling	4th Tues.
Parkersburg Academy	Robert C. Lincicome	Parkersburg	Dwight P. Cruikshank	Parkersburg	1st Thurs.
Potomac Valley	Robert W. Bess, Jr.	Piedmont	William H. Boone	Keyser	2nd Wed.
Preston	F. A. Kennedy	Hopemont	C. Y. Moser	Kingwood	4th Thurs.
Raleigh	B. B. Richmond	Beckley	Richard G. Starr	Beckley	3rd Thurs.
Summers	J. W. Stokes	Hinton	D. W. Ritter	Hinton	3rd Mon.
Taylor	K. H. Trippett	Grafton	Paul P. Warden	Grafton	Last Thurs
Wetzel	Lemoyne Coffield	N. Martinsville	Charles P. Watson	New Martinsville	Monthly
Wyoming	Jorge Piedra	Mullens	Ross E. Newman	Mullens	Quarterly

Whether you're a teacher correcting exams. A student cramming for them. A housewife cleaning up after the kids. Or a businessman working late at night. Whoever you are, things go better when you pause and refresh with ice-cold Coca-Cola.

MARCH
1964

Vol. 60 No. 3

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Clarksburg

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Member 1964

CONTENTS

Scientific Articles

The Role of the Surgeon in the Management of Chronic Ulcerative Colitis—Edward S. Judd, M. D. 61

Contact Dermatitis in the Home and in Industry —Eugene S. Bereston, M. D. 66

A Special Report by the Medical Economics Committee—George R. Callender, Jr. M. D. 74

The President's Page

The Status of Current Medical Legislation—Charles L. Goodhand, M. D., President, West Virginia State Medical Association 78

Editorial

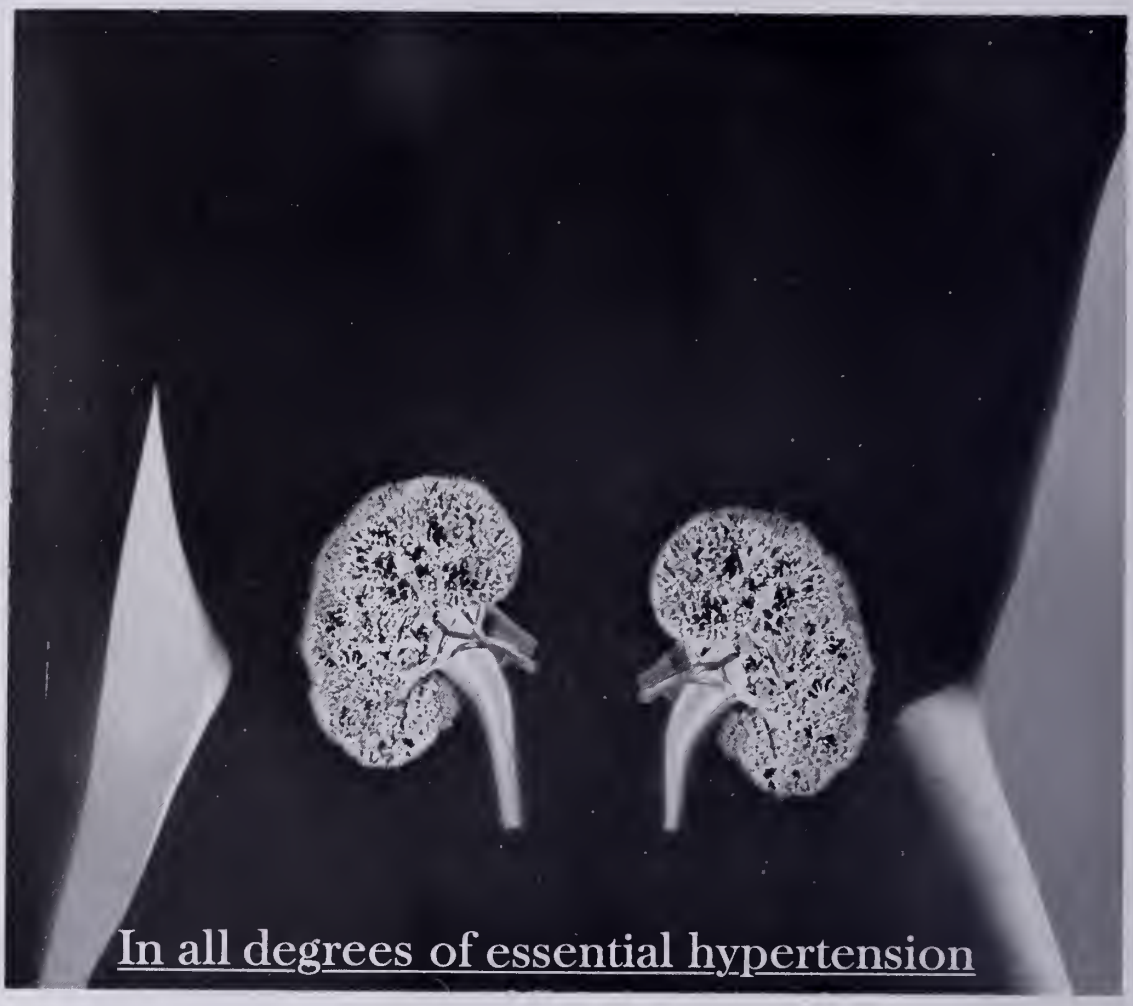
On Guard, Fellow Sons of Aesculapius 79
Medical News of the Time 80
The New Law 80

General News

Dr. Gresham Honor Guest at Annual Meeting 81
ACP Meeting in Atlantic City 82
W. Va. Acad. Oph. and Otol. Meeting 82
PG Course in Anesthesiology 84
'Travel Meeting' of Ob.-Gyn. Society 83
Drastic Changes in Disease Patterns 84
Dr. Ross E. Newman Named to Licensing Board 85
Dr. Welch To Speak in Wheeling 86

Special Departments

WVU Medical Center News xx
The Month in Washington xxii
Obituaries xxiv
County Societies xxvii
The Woman's Auxiliary xxx
Directory of Physicians in Limited Practice xxxvii
Index to Advertisers xl



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Research in the Service of Medicine

WVU Medical Center
—News—

DEAN Clark K. Sleeth announced that 61 students have been accepted as members of the first-year class at the West Virginia University School of Medicine. Fifty-one members of the class, which will enroll next September, are residents of West Virginia.

Selections for the seventh class of students accepted in the School of Medicine were based on more than 1,000 inquiries received from residents and non-residents. Of that number, 142 West Virginia residents applied and each was given individual consideration by an eight-member faculty committee which spent more than 500 hours interviewing applicants between September 1, 1963, and February 1, 1964. An additional 147 students residing outside West Virginia were allowed to make formal application and 10 were accepted.

The WVU School of Medicine has granted 61 M. D. degrees and will graduate another 42 persons in June. Both the present freshman and sophomore classes have 60 students and there are 59 juniors.

Following are the home towns, name and undergraduate college or university of the new class:

Bluefield—James W. Baker, Marshall University.

Buckhannon—Bruce A. Butterfield, W. Va. Wesleyan.

Charleston—Philip Corey, Ohio State University; Fred Holt, Georgia Tech; George B. Kallam, WVU; David King, Yale and Morris Harvey; John V. Merrifield, Morris Harvey and W. Va. State; James B. Shepherd, Jr., Amherst College; Ronald L. Wilkinson, WVU.

Chesapeake—James E. Cottrell, Morris Harvey.

Chicago, Illinois—David J. Evans, University of Illinois and Loyola University.

Clairton, Pennsylvania—William A. Dow, St. Vincent's College.

Clarksburg—Barry R. Friedlander, University of Pennsylvania; Francis A. Nardella, WVU; Miss Suzanne Saliga, St. Mary of the Springs; Lynwood D. Zinn, Jr., Washington & Lee and University of Michigan.

Crab Orchard—Thomas Mann, Marshall and WVU.

Danville—Edward Wheatley, Marshall.

Dunbar—John G. Walker, University of Virginia.

Fairmont—Stephen R. Humpherys, Rutgers University and Muhlenberg College.

Flushing, New York—Kenneth Holwitt, New York University.

Glenville—Carl E. Nichols, Glenville State College.

Hinton—Frederick C. Newton, WVU.

Huntington—Charles Abraham, WVU; Miss Sally L. Reggel, Denison University; Richard R. Six, Marshall; Tommy Turner, Marshall.

° Compiled from material furnished by Howard Lewis, Director, Medical Center News and Information Services, Morgantown, West Virginia.

Inwood—William S. Miller, Shepherd State College and WVU.

Keyser—Joseph Giffin, WVU.

Manchester, Connecticut—Kenneth Bird, Jr., Rensselaer Polytechnic Institute and University of Connecticut.

Martinsburg—Timothy K. Bowers, WVU; Fred A. Brindle, WVU; Marion B. Tallent, Jr., WVU.

Masontown, Pennsylvania—Ronald W. Dillow, WVU.

McClellandtown, Pennsylvania — Joel C. Gaydos, WVU.

Montgomery—William O. DeWeese, Maryville College.

Morgantown—Donald R. Barnett, WVU; Charles R. Goshen, Columbia University; Daniel E. Michel, WVU; Jack L. Vespaziano, WVU.

Parkersburg—Tommy E. Enoch, University of Cincinnati; George Ulch, University of Cincinnati and Marietta College.

Park Ridge, Illinois—Dennis A. Greene, University of Chicago.

Philadelphia—Edmond H. Blau, Temple University and University of Pennsylvania.

Philippi—Leonard G. Prutsok, WVU.

Pittsburgh—David B. Myers, University of Pittsburgh.

Rainelle—John W. Cavendish, II, WVU.

Richwood—Johnsey L. Leef, Jr., Marshall.

Ripley—William E. Walker, Marietta College and Marshall University.

St. Albans—James N. Foster, Vanderbilt University and Thomas L. Hildebrand, WVU.

South Charleston—John W. Byrd, West Virginia State College.

Scott Depot—Lance P. Stealy, Morris Harvey College and Johns Hopkins University.

Waterford, Pennsylvania—James Markham, Emory University.

Webster Springs—Larry A. Dodd, WVU.

Weirton—James W. Campbell, WVU; Theodore H. Neidengard, WVU; John J. Mikita, Denison University and John A. Rurak, University of Notre Dame.

Wheeling—Miss Susan K. Ewing, Oberlin College; Robert L. Joseph, West Liberty State College and WVU.

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The Month in Washington

A finding by a special Federal government committee of physician and scientist experts that cigarette smoking is a serious health hazard gave impetus to further research with the objectives of determining the harmful factors in smoking and eliminating them.

The House of Delegates of the American Medical Association had authorized a basic research program into smoking and health before the special committee's report was made public in January. The House Agriculture Committee approved legislation authorizing a Federal research program into how to make cigarettes safe. The Johnson Administration included in its fiscal 1964-'65 budget an appropriation request for $5 million for research on smoking.

The 10-member Advisory Committee to the Surgeon General of the Public Health Service reached the unanimous conclusions that:

"Cigarette smoking is a health hazard of sufficient importance in the United States to warrant appropriate remedial action . . .

"In view of the continuing and mounting evidence from many sources, it is the judgment of the committee that cigarette smoking contributes substantially to mortality from certain specific diseases and to the overall death rate . . .

"Cigarette smoking is causually related to lung cancer in men: the magnitude of the effect of cigarette smoking far outweighs all other factors. The data for women, though less extensive, point in the same direction."

'Give Careful, Thoughtful Attention'

Dr. Edward R. Annis, president of the American Medical Association urged "the American people to give careful, thoughtful attention to this report and to the strong evidence linking smoking to cancer and other diseases."

"It should be noted that the report indicates that further research could be valuable and, in this connection, Surgeon General Luther L. Terry expressed approval of the American Medical Association's comprehensive, long-range program of basic research on tobacco and health, which was announced last December," Doctor Annis said.

"Despite the strong evidence against smoking which has been amassed in this report, it is unrealistic to assume that the American people are suddenly going to quit smoking. Because people will continue to smoke, research efforts should try to find how tobacco smoke affects health and, if possible, to eliminate whatever element in the smoke that may induce disease. This is what we hope to do through the AMA research project on tobacco and health."

Three members of the Surgeon General's Advisory Committee were named to the five-member committee that will direct the American Medical Association Education and Research Foundation's long-range program of research on tobacco and health. They are:

• **From the Washington Office of the American Medical Association.**

Dr. Maurice H. Seevers, Chairman of the Department of Pharmacology at the University of Michigan Medical School and named chairman of the AMA-ERF committee; Dr. John B. Hickman, Chairman of the Department of Internal Medicine at the University of Indiana Medical School, and Dr. Charles LeMaistre, Professor of Internal Medicine, Southwestern Medical School.

The other two members of the AMA-ERF committee are Paul S. Larson, Ph.D., Chairman of the Department of Pharmacology at the Medical College of Virginia, and Dr. Richard J. Bing, Chairman of the Department of Medicine, Wayne State University College of Medicine.

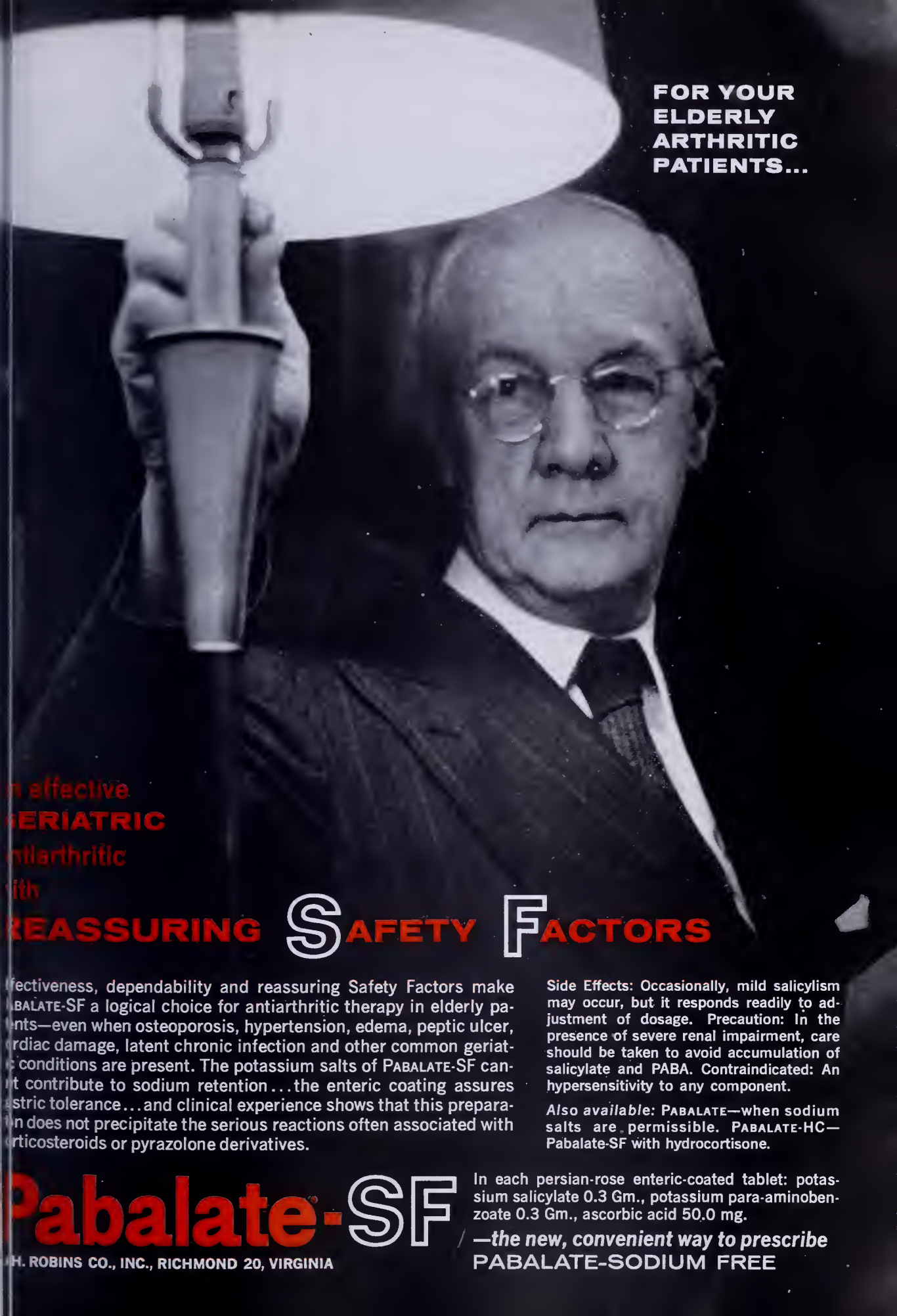
Initial Appropriation of $500,000

The AMA Board of Trustees made an initial appropriation of $500,000 for the research program, and announced contributions would be accepted from other foundations, industry, voluntary health associations, physicians and other sources—but only if given without restrictions.

On the clear understanding that there were absolutely no restrictions attached, a contribution of $10 million was accepted from six tobacco companies. These funds will be made available over a five-year period as needed.

The first remedial action advanced by the Federal government was new cigarette advertising regulations proposed by the Federal Trade Commission. The rules, subject to modification after open hearings in March, would require that in all cigarette advertising or labeling:

There be a clear warning that cigarette smoking may cause death; there be no implication that cigarette smoking promotes good health or physical well-being, and there be no claim that smoking one brand is less harmful than smoking another. The Federal government banned the distribution of free cigarettes in Public Health Service, military, Indian and Veterans Administration hospitals. The government also launched educational campaigns pointing out the hazards of smoking to patients in the hospitals.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Obituaries

ALFRED SPATES BRADY, JR., M. D.

Dr. Alfred Spates Brady, Jr., 59, of Charleston, died on February 3 at his home in that city after an extended illness.

Doctor Brady was a native of Fairmont and was graduated from Yale University. He attended the two-year School of Medicine at West Virginia University and received his M. D. degree in 1934 from the New York University College of Medicine.

He served an internship at the Jersey City Medical Center in 1935 and was licensed to practice in West Virginia the following year. During World War II he served in the Medical Corps of the United States Navy.

Doctor Brady was a Fellow of the American College of Cardiology and an honorary life member of the Kanawha Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by a daughter, Mrs. James A. Haught of Charleston; a stepdaughter, Mrs. Leonard Schrecengost of Creighton, Pennsylvania; and two sisters, Mrs. Mary Wills of Piedmont and Mrs. Merritt Wilson, Jr., of Elkins.

DOFF D. DANIEL, SR., M. D.

Dr. Doff D. Daniel, Sr., 68, of Beckley, a member of the Medical Licensing Board of West Virginia since 1949 and the father of two Beckley physicians, died at his home in that city on February 4.

Doctor Daniel was born at Glen Daniel, Raleigh County, in 1895, the son of Dr. George P. and Nettie Calloway Daniel. He attended Concord Normal School in Athens and was graduated from West Virginia Wesleyan College where he was a star on the baseball team.

He received his M. D. degree in 1921 from Jefferson Medical College in Philadelphia and was licensed to practice in West Virginia the following year when he became a coal company physician at Eccles. He remained there until 1945 when he moved his practice to Beckley.

Doctor Daniel was a member of the Raleigh County Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, Mrs. DeMerse Morton Daniel, he is survived by three sons, Dr. Doff D. Daniel, Jr., Dr. John M. Daniel and George P. Daniel, all of Beckley; one daughter, Mrs. Joan DeMerse Powell of Naples, Florida; one brother, Dr. Ross P. Daniel of Beckley; and eight grandchildren.

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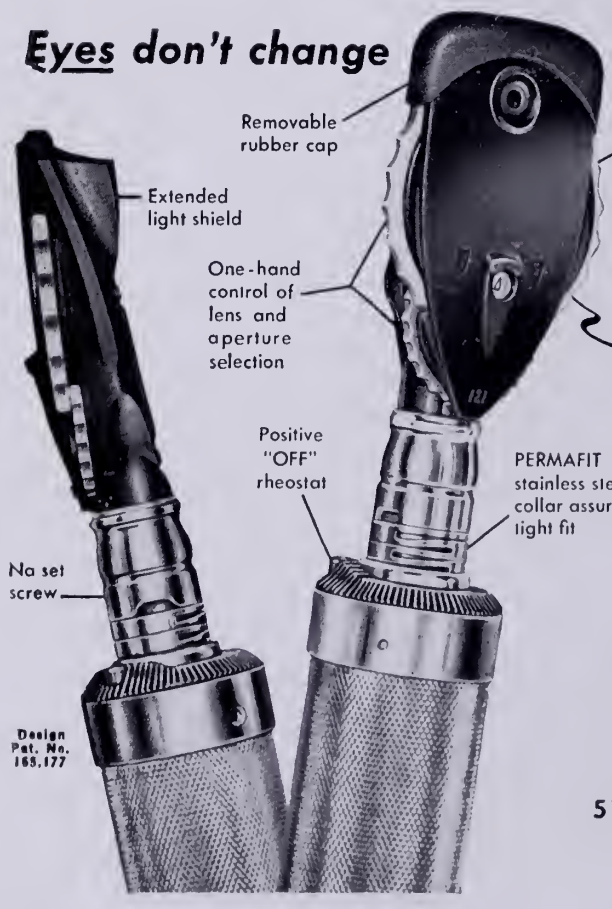

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In a smooth, white, water-washable vanishing cream base with a pH of approximately 5.0. Inactive ingredients: liquid petrolatum, white petrolatum, distilled water, propylene glycol, polyoxyethylene polyoxypropylene compound, emulsifying wax and 0.25% methylparaben as preservative.

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MARCUS EMMETT FARRELL, M. D.

Dr. Marcus Emmett Farrell, 56, of Clarksburg, died on January 12 at his home in that city.

Doctor Farrell was born at Littleton, Wetzel County, on April 4, 1907, the son of Bernard J. and Margaret Connelly Farrell. He was graduated from the University of Notre Dame and received his M. D. degree in 1932 from the Harvard Medical School.

He served an internship at Mercy Hospital in Pittsburgh, 1933, and a residency at the Huntington Memorial Hospital in Boston, 1934. He took postgraduate work in pediatrics at the Massachusetts General Hospital in Boston.

During World War II, Doctor Farrell served in the Medical Corps of the United States Navy and was released in 1946 with the rank of Lt. Commander.

Doctor Farrell, who was certified in pediatrics, was a member of the Harrison County Medical Society, West Virginia State Medical Association and American Medical Association. He also was active for many years in the work of the National Society for Crippled Children and Adults and its affiliates on the State and county levels.

Besides his widow, he is survived by two sons, John D. Farrell, a student at the University of Pittsburgh School of Medicine, and Lt. Marcus Farrell, serving with the United States Navy in the Pacific; and three brothers, the Rev. Msgr. Benjamin F. Farrell of Moundsville, and Albert and Robert H. Farrell, both of Philadelphia.

* * * *

R. W. QUAINTANCE, M. D.

Dr. R. W. Quaintance, 88, of Slate Mills, Virginia, died on January 20 at his home in that community.

Doctor Quaintance was a native of Slate Mills and was graduated from the College of William and Mary. He received his M. D. degree in 1901 from the Medical College of Virginia and was licensed to practice in West Virginia the following year.

He was one of the first physicians for the New River and Pocahontas Coal Company at Minden in Fayette County. He later practiced at Lundale, Logan County, before moving to Slate Mills in 1944. He was a former member of the Logan County Medical Society and the West Virginia State Medical Association.

PG Course in Hematology

The University of Virginia School of Medicine will present a one-day postgraduate course on "Clinical and Laboratory Problems in Hematology" at the School of Medicine Amphitheater in Charlottesville, Virginia, on March 20.

The registration fee is $20. Further information may be obtained by writing to the Director, Continuation Education Program, Box 329, University of Virginia Hospital, Charlottesville, Virginia.

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County Societies

CABELL

Dr. Clarence H. Boso was installed as president of ıe Cabell County Medical Society at the regular ıonthly meeting which was held at the Hotel Fred-rick in Huntington on January 9. He succeeds Dr. ack Leckie of Huntington.

Doctor Leckie, who was presented with a plaque ı appreciation for his service as president, thanked is committees for their fine work during the past ear. He said the success of the Sabin Oral Polio pro-ram indicated the potential benefits which can be erived from the participation of a well-organized ıedical society in community health projects.

Dr. Charles A. Hoffman was unanimously reelected s a member of the Advice and Deportment Com-ıittee.

Dr. Albert C. Esposito, president elect of the West irginia State Medical Association, presented a re-ort on recent meetings of the Council of the As-ociation.—W. L. Neal, M. D., Secretary.

* * * *

HARRISON

Dr. Russell V. Lucas, Jr., of Morgantown, was the uest speaker at the regular monthly meeting of the arrison County Medical Society which was held at

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Orthopedic Surgery:
C. B. Buffington, M. D.
G. B. Krivchenio, M. D.

Thoracic Surgery:
Doniel W. Dickinson, M. D.

Obstetrics ond Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfoss, M. D.

Urology:
Richord D. Gill, M. D.

Neurological Surgery:
Jomes S. Rogers, M. D.
Fronk M. Hudson, M. D.

Internal Medicine:
Chorles H. Hiles, M. D.
Albert M. Volentine, M. D.
Jomes A. Jocob, Jr., M. D.

Psychiatry ond Neurology:
Albert L. Wonner, M. D.
Stephen D. Word, M. D.
Dovid H. Smith, M. D.

Roentgenology:
Williom K. Kolbfleisch, M. D.

Clinicol Loborotories:
Noncy Fondriest, M. T.

Technologists:
Electrocordiogrophy:
Potricio Postor, R. N.
Electroencephologrophy:
JoAnn Hostings
Roentgenology:
Evelyn Forester, R. T.

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HUNTINGTON, WEST VIRGINIA

the Stonewall Jackson Hotel in Clarksburg on February 6.

Doctor Lucas, Assistant Professor of Pediatrics at the West Virginia University School of Medicine, presented a paper on congenital heart diseases.

Dr. Robert S. Wilson, the president, presided at the business meeting. Drs. Robert McCune and Herbert N. Shanes of Grafton were guests at the meeting.

* * * *

KANAWHA

Dr. George L. Grubb was installed as President of the Kanawha Medical Society during the annual dinner-dance which was held at the Press Club in Charleston on January 18. Other new officers are as follows:

Dr. Edward Jackson, vice-president, and Dr. Henry R. Glass, Jr., secretary-treasurer. Dr. Kenneth G. McDonald, the retiring president, will serve as chairman of the Council.

One-hundred-sixty persons attended the meeting and the guest speaker was Mr. Ralph Porterfield of Atlanta, Georgia.

Plaques for outstanding community services in health or a related field were awarded to Drs. Peter A. Haley, Page H. Seekford, and Edwin M. Shepherd and Mesdames A. B. Curry Ellison and J. Dennis Kugel.—Henry R. Glass, Jr., M. D., Secretary-Treasurer.

* * * *

McDOWELL

Dr. John S. Cook was installed as president of the McDowell County Medical Society during a meeting held at the Stevens Clinic Hospital in Welch on January 8. Other new officers are as follows.

Dr. J. Hunter Smith, vice president; Dr. David J. Skewes, secretary; and Dr. Charles F. McCord, treasurer.

During the business meeting, Doctor McCord presented a financial report and Dr. John H. Murry gave a report on the Rheumatic Fever Control Program.

Fourteen members attended the meeting.—David J Skewes, M. D., Secretary.

* * * *

PARKERSBURG ACADEMY

Dr. D. Franklin Milam of Morgantown was the guest speaker at the February meeting of the Parkersburg Academy of Medicine which was held at the American Legion Home in Parkersburg.

Doctor Milam, Professor and Chairman of the Division of Urology at the West Virginia University School of Medicine, spoke on "Modern Concepts of Pediatric Urology."

Dr. Robert C. Lincicome, the president, presided at the business meeting.

* * * *

PRESTON

Dr. W. Parke Johnson, Jr., of Masontown, was elected president of the Preston County Medical Society at a joint meeting of the Society and its Auxiliary which was held at the Howard Hotel in Rowlesburg

on January 23. He succeeds Dr. F. A. Kennedy of Hopemont.

Dr. John F. Lehman of Kingwood was named vice president and Dr. C. Y. Moser, also of Kingwood, reelected secretary-treasurer.

Dr. Seigle W. Parks of Fairmont, vice president of the West Virginia State Medical Association, was the guest speaker. He discussed the physician's role in cooperating with the West Virginia Department of Welfare in the care of the indigent.

* * * *

RALEIGH

The regular meeting of the Raleigh County Medical Society was held in Beckley on January 16.

Dr. Warren D. Elliott, the vice president, presided at the business meeting. Drs. A. D. Bolton, Stephen T. J. Lee and Clifford A. Stevenson were unanimously elected to membership in the Society.

* * * *

WYOMING

Dr. Jorge Piedra of Mullens was elected president of the Wyoming County Medical Society at the regular quarterly meeting which was held at the Wyoming Hotel in Mullens on January 12. He succeeds Dr. George F. Fordham of Mullens.

Dr. Frank J. Zsoldos was named vice president and Dr. Ross E. Newman secretary-treasurer.

Radiology:
KARL J. MYERS, M. D.

Pathology:
S. D. WU, M. D.

Surgery:
HU C. MYERS, M. D.
A. KYLE BUSH, M. D.

Gynecology and Obstetrics:
RAYMOND W. CRONLUND, M. D.

Internal Medicine:
JOHN E. LENOX, M. D.
J. L. RITTMEYER, M. D.
ERNEST G. GUY, M. D.

Pediatrics:
CORA C. LENOX, M. D.

Dentistry:
GLENN B. POLING, D. D. S.

Anesthesiology
G. E. HARTLE, M. D.

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Third Vice President: Mrs. Joe N. Jarrett, Oak Hill
Fourth Vice President: Mrs. Wilson P. Smith, Huntington
Treasurer: Mrs. Grover C. Hedrick, Jr., Beckley
Recording Secretary: Mrs. Robert J. Tchou, Williamson
Corresponding Secretary: Mrs. James T. Spencer, Charleston
Parliamentarian: Mrs. John W. Hash, Charleston

CABELL

Mrs. L. Dale Simmons of Clarksburg was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Cabell County Medical Society which was held at the Hotel Frederick in Huntington on February 11.

Mrs. Simmons, Legislative Chairman of the Woman's Auxiliary to the West Virginia State Medical Association, discussed legislation at both the national and State levels.

Those planning the luncheon included Mesdames R. W. Hibbard, James P. Carey, John M. Bobbitt, Charles M. Polan, Gerald J. Eder, Warren N. Morford, Lawrence B. Gang, Samuel Biern, Jr., Russell R. Brandon, Lewis C. Richmond, Sr., Gates J. Wayburn and G. G. Hunter.

* * * *

HARRISON

Dr. James F. Carruth of Morgantown, Associate Professor of Psychology and Director of the Student Counseling Service at West Virginia University, was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Harrison County Medical Society which was held at the Stonewall Jackson Hotel in Clarksburg on February 6.

Doctor Carruth's topic was "The Problems of Normal Children." He said, "the more protective the parent, the more harm done to the child."

He stressed allowing freedom in order to teach independence and thereby to obtain confidence. He emphasized that children learn primarily through the proper example and discipline of their parents, this discipline not being punishment, but rather guidance in conforming to the customs of modern society.

Mrs. Robert S. Wilson, Mental Health Chairman, was in charge of the program and introduced Dr. Arthur Bryant, Chief Clinical Psychologist at the Clarksburg VA Hospital.—Mrs. Karl A. Dillinger, Publicity Chairman.

* * * *

KANAWHA

The regular monthly meeting of the Woman's Auxiliary to the Kanawha Medical Society was held at the

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home of Dr. and Mrs. Edwin M. Shepherd in Charleston on January 14.

Dr. Robert C. Bock, a past president of the Kanawha Medical Society, presented an enlightening talk on proposed medical legislation at the State and national levels.—Mrs. James H. Walker, Press and Publicity Chairman.

* * * *

MARION

The Woman's Auxiliary to the Marion County Medical Society held a benefit bridge party in the parish house of Christ Episcopal Church in Fairmont on February 4.

Proceeds from the affair were earmarked for the American Medical Association's Education and Research Fund (AMA-ERF). Mrs. Robert G. Janes is chairman of the AMA-ERF Committee.

Hostesses were Mesdames L. Rush Lambert, Jack C. Morgan, Robert B. Hamilton and Frederick G. Shaffer.

* * * *

McDOWELL

Mrs. O. L. Robinson, librarian at the McDowell County Public Library, was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the McDowell County Medical Society which was held at the home of Dr. and Mrs. Dante Castrodale in Welch on January 8.

Mrs. Robinson reviewed the book, "Voices of Glory," which was written by Davis Grubb, a native West Virginian.

MINGO

Mrs. W. H. Price and Mrs. J. E. Johnson were hostesses at a luncheon meeting of the Woman's Auxiliary to the Mingo County Medical Society which was held at the Mountaineer Hotel in Williamson on January 30.

Mrs. Robert J. Tchou, the president, presided at the business meeting. It was announced that the "Doctors' Day Dinner" would be held at the home of Dr. and Mrs. Russell A. Salton on April 4.—Mrs. Frank J. Burian, Secretary.

* * * *

MONONGALIA

The regular monthly meeting of the Woman's Auxiliary to the Monongalia County Medical Society was held at the Red Cellar in Morgantown on February 4.

Mrs. French R. Miller, the president, presided at the business meeting. Plans were made for a guest night in April.

Hostesses for the dinner were Mrs. Arch Hogue, Mrs. H. A. Rich, Mrs. Carl H. Cather, Jr., Mrs. P. D. Crynock and Mrs. Samuel C. Dotson, Jr.—Mrs. John J. Lawless, Publicity Chairman.

* * * *

OHIO

Kitty J. Doepken, Woman's Page Editor of the Wheeling News-Register, was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Ohio County Medical Society which was held at the Fort Henry Club on January 28.

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Mrs. Herbert G. Dickie, Jr., the president, presided at the business meeting.

Mrs. Charles D. Hershey served as hostess for the luncheon meeting. She was assisted by Mesdames James C. Hazlett, Albert J. Fisher, L. P. Hudnall, Donald H. Hofreuter and Albert L. Wanner.

Free Medicine?

For some reason American Medicine of the sixties is "up for grabs." Politicians want to control it. Labor wants it for free. The "aged" have been jockeyed into the position of demanding as a right what has never been denied them. On the fringes are the welfare elements, the socio-economic wizards, the "do-gooders," all yapping at the heels of a suddenly bedeviled medical profession whose chief reaction is one of deep puzzlement.

Considered as a specialized profession has American Medicine done badly by its trust to care for the medical needs of our society? Has it been remiss in progressing in an era of rapid progress? Has it neglected to do for the well that which needed doing to keep them well, and to do for the sick what no one can do better? Why the hue and cry over medicine?

Thirty-five years ago there was no such hue and cry. Then those who are now aged were just planning for a future which they alone would be responsible for. In an era far less prosperous but relatively more stable, it was possible to plan ahead. Insurance companies promised retirement to an enjoyable leisure with an insured income of $150.00 a month for those who planned ahead. Whose fault was it that their nest egg shrank to a third of its original value when they became "the aged."

Could it be that the drive for free medicine is motivated by money? We in medicine protest that we have no control over the nation's finances. The responsibility must rest on those who control money. To turn to government control of medicine in order to cheapen medicine is to really cheapen it, but not in the financial sense. Government has never operated anything for less money, whether it ran the railroads or built ships. The common denominator of all government control has been a sky-rocketing rise in cost of operation, a corresponding slide in efficiency, and an increase in taxes to make up the inevitable deficits. To expect that government operation of medicine would be less costly is a delusion. To contemplate the end result of governmental control is horrifying.

We seem to be living in a society whose code of ethics and moral tone has deteriorated to the point where the difference between right and wrong is blurred. Segments of our population who once took pride in self-reliance and the ability to solve their own problems, are no longer shocked at a generation which has been brought up to expect that no matter how badly they fail, a government agency will bail them out. A generation which has been conditioned to look to government for all forms of assistance has even perfected techniques whereby such assistance permits them to

live without contributing anything to the society on which they are dependent.

Nations have lived or died because their moral codes, once high, deteriorated. When in the past, great empires fell one could trace their decline in large part to the increased paternalism of their governments and the declining moral codes of their populaces. We have our own modern examples of the disastrous effects of public avarice coupled with government temptations for political gain.

The greatest empire the world has known, has disingrated before our eyes under the misguided tutelage of socialist governments. By contrast, our defeated enemies have prospered beyond their wildest dreams where the democratic process has permitted them the benefits of private enterprise.

American medicine is great because the American Medical Profession is great. It has perfection as its goal, and if it falls short of perfection it is only because, like everyone else, doctors are human.

There is no such thing as free medicine. There is only the choice of paying for medicine on a free and individual basis, or of paying for it on a controlled governmental basis, and paying, and paying, and paying.—Morris P. Pitcock, M. D., in *Connecticut Medicine*.

Books Received

CURRENT DIAGNOSIS & TREATMENT—By Henry Brainerd, M. D., Sheldon Margen, M. D., Milton J. Chatton, M. D., and Associate Authors. Pp. 870. 1964. Lange Medical Publications, P. O. Box 1215, Los Altos, California. Price $9.50.

★ ★ ★ ★

CURRENT PEDIATRIC THERAPY—By Sydney S. Gellis, M. D., Professor of Pediatrics and Chairman of the Department of Pediatrics, Boston University School of Medicine and Director of Pediatrics, Boston City Hospital; and Benjamin M. Kagan, M. D., Director, Department of Pediatrics, Cedars of Lebanon Hospital, Los Angeles, and Clinical Professor of Pediatrics, University of California, Los Angeles. Pp. 747. Philadelphia and London: W. B. Saunders Company. 1964. Price $16.00.

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PERSONNEL IN WORLD WAR II—By John H. McMinn, Ph.D., and Max Levin, A. M. Prepared and published under the direction of Lieutenant General Leonard D. Heaton, The Surgeon General, United States Army; Editor in Chief, Colonel John Boyd Coates, Jr., MC, USA; and editor for Personnel, Charles M. Wiltse, Ph.D., Litt. D. Pp. 548, with numerous illustrations. Superintendent of Documents, U.S. Government Printing Office, Washington 25, D. C. 1963. Price $6.

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OCCUPATIONAL HEALTH AND MANTALENT DEVELOPMENT—By Robert Collier Page, M. D. Pp. 680. Physicians' Record Company, 3000 South Ridgeland Avenue, Berwyn, Illinois. 1963. Price $18.50.

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ELEMENTARY MEDICAL STATISTICS—By Donald Mainland, M.B., CH.B., D.SC., F.R.S.S., F.R.S.C., F. A. S. A:, Professor of Medical Statistics, New York University Medical Center. Pp. 381. W. B. Saunders Company: Philadelphia and London. 1963, Second Edition. Price $9.00.

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MAN AND HIS FUTURE—Edited by Gordon Wolstenholme. Pp. 410, with 8 illustrations. Little, Brown and Company, Boston, Toronto. 1963. Price $6.00.

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PATHOGENESIS OF LEPROSY—Edited by G. E. W. Wolstenholme, O.B.E., M.A., M.B., M.R.C.P. Pp. 101, with 19 illustrations. Little, Brown and Company, Boston. 1963. Price $2.95.

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DISEASES OF THE SKIN For Practitioners and Students—By George Clinton Andrews, M. D., Clinical Professor Dermatology (Retired), College of Physicians and Surgeons, Columbia University; Consulting Dermatologist to the Presbyterian Hospital, Columbia-Presbyterian Medical Center, New York City; and Anthony N. Domonkos, M. D., Associate Clinical Professor of Dermatology, College of Physicians and Surgeons, Columbia University; Attending Dermatologist to the Presbyterian Hospital, Columbia-Presbyterian Medical Center, New York City. Pp. 749, with numerous illustrations.

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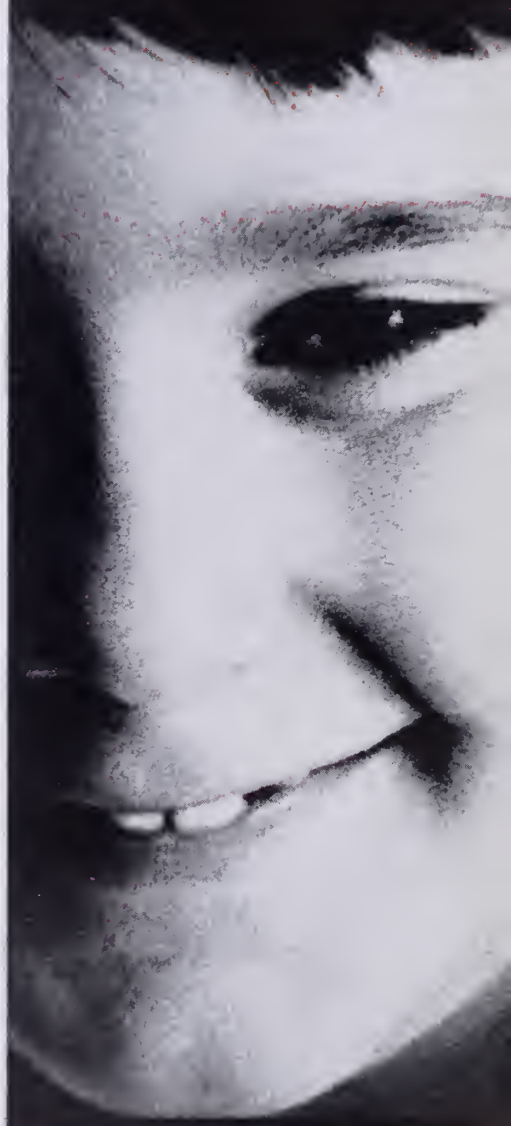

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REVIEW OF MEDICAL PHYSIOLOGY—By William F. Ganong, M. D., Associate Professor of Physiology, University of California School of Medicine, San Francisco; and Consulting Physiologist, Kaiser Foundation Hospital, San Franciso. Pp. 577, with numerous illustrations. Lange Medical Publications, P. O. Box 1215, Los Altos, California. 1963. Price $6.50.

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THE FAT BOY GOES POLY-UNSATURATED—By Elmer Wheeler. Pp. 156, with illustrations. Doubleday and Company, Inc., 575 Madison Avenue, New York, New York. 1963. Price $3.50.

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A HISTORY OF WINE AS THERAPY—By Salvatore P. Lucia, M. D. Pp. 234. J. B. Lippincott Company: Philadelphia and Montreal. 1963.

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HANDBOOK OF THE PRACTICE OF ANESTHESIOLOGY—By John R. S. Shields, M.B., Ch.B., F.F.A.R.C.S., Associate Professor of Anesthesiology, Department of Surgery, Washington University School of Medicine, St. Louis, Missouri. Pp. 203, with illustrations. The C. V. Mosby Co., 3207 Washington Boulevard, St. Louis 3, Missouri. 1963. Price $6.85.

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PEDIATRIC CARDIOLOGY—By Alexander S. Nadas, M. D., F.A.A.P., Associate Clinical Professor of Pediatrics, Harvard Medical School; Cardiologist, The Children's Hospital; Physician, Sharon Cardiovascular Unit, Children's Hospital Medical Center, Boston. Pp. 828, with numerous illustrations. Philadelphia and London: W. B. Saunders Company. 1963, Second Edition. Price $16.00.

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GYNECOLOGIC AND OBSTETRIC PATHOLOGY—By Edmund R. Novak, M. D., Assistant Professor of Gynecology, The Johns Hopkins Medical School; and J. Donald Woodruff, M. D., Associate Professor of Gynecology, The Johns Hopkins Medical School. Pp. 713, with 761 illustrations, 31 of which are in color. W. B. Saunders Company: Philadelphia and London. Fifth Edition. 1962. Price $16.00.

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"RESULTS OF SURGERY FOR PEPTIC ULCER" (A Cooperative Study by Twelve VA Hospitals)—Edited by R. W. Postlethwait, M. D. Pp. 308. Philadelphia and London: W. B. Saunders Company. 1963. Price $8.00.

"TEXTBOOK OF MEDICINE" (Cecil-Loeb)—Edited by Paul B. Beeson, M. D., Ensign Professor of Medicine, Yale University School of Medicine; and Walsh McDermott, M. D., Livingston Farrand, Professor of Public Health, Cornell University Medical College. Pp. 1835. Philadelphia and London: W. B. Saunders Company. 1963. Eleventh Edition. Price, $19.50, single volume; $23.50, 2-volume set.

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pH and DISSOCIATION: A Learning Program for Students of The Biological and Medical Sciences—By Halvor N. Christensen, Ph.D. Pp. 60, with illustrations. W. B. Saunders Company: Philadelphia and London. 1963. Price $1.75.

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"CROSSEN'S SYNOPSIS OF GYNECOLOGY"—By Daniel Winston Beacham, M. D. and Woodard Davis Beacham, M. D. Pp. 371, with numerous illustrations. The C. V. Mosby Company, St. Louis, Missouri. 1963. Sixth Edition. Price $7.50.

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"PHYSICAL DIAGNOSIS"—By John A. Prior, M. D., Professor of Medicine & Associate Dean, Ohio State University College of Medicine, Columbus; and Jack S. Silberstein, M. D., Clinical Associate Professor of Medicine, Ohio State University College of Medicine. Pp. 455, with 277 illustrations. The C. V. Mosby Company, St. Louis. 1963. Second Edition. Price $8.50.

Make Your Reservation Now!

Members of the West Virginia State Medical Association are urged to make reservations without delay for accommodations during the 97th Annual Meeting at The Greenbrier in White Sulphur Springs, August 20-22, 1964. Application forms for room reservations were enclosed in a bulletin mailed recently to each member. The completed forms should be mailed directly to the Reservation Manager, The Greenbrier, White Sulphur Springs, West Virginia.

OFFICERS OF COMPONENT SOCIETIES

Society	President		Secretary		Meetings
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Boone	A. E. Glover	Madison	Harold H. Howell	Madison	2nd Wed.
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Cabell	Clarence H. Boso	Huntington	W. L. Neal	Huntington	2nd Thurs.
Central West Virginia	Donald S. Groves	Summersville	R. L. Chamberlain	Buckhannan	As Scheduled
Eastern Panhandle	F. A. Hamilton, Jr.	Martinsburg	E. Andrew Zepp	Martinsburg	2nd Wed.
Fayette	Chuan H. Lee	Montgomery	D. Alene Blake	Oak Hill	1st Wed.
Greenbrier Valley	Harvey A. Martin	White Sul. Spgs.	Stuart T. Bray	White Sul. Spgs.	2nd Wed
Hancock	David H. Williams	Weirton	Ray S. Greco	Weirton	2nd Tues.
Harrison	Robert S. Wilson	Clarksburg	Richard K. Hanifan	Clarksburg	1st Thurs.
Kanawha	George L. Grubb	Charleston	Henry R. Glass, Jr.	Charleston	2nd Tues.
Logan	George R. Mullins	Logan	Thomas P. Long	Man	2nd Wed.
Marion	James E. Watring	Fairview	G. Thomas Evans	Fairmont	Last Tues.
Marshall	Kenneth J. Allen	Moundsville	J. W. Myers	Moundsville	Semi-Ann.
Mason	C. Leonard Brown	Pt. Pleasant	Richard L. Slack	Pt. Pleasant	Bi-Monthly
McDowell	John S. Cook	Welch	David J. Skewes	Coalwood	2nd Wed.
Mercer	John J. Mahood	Bluefield	J. Brookins Taylor	Bluefield	3rd Mon.
Mingo	Andrew H. Henderson	Williamson	Russell A. Saltan	Williamson	2nd Wed.
Monongalia	Reginald Krause	Morgantown	W. E. King	Morgantown	1st Tues.
Ohio	Joseph L. Curry	Wheeling	A. J. Purpura	Wheeling	4th Tues.
Parkersburg Academy	Robert C. Lincicome	Parkersburg	Dwight P. Cruikshank	Parkersburg	1st Thurs.
Potomac Valley	Robert W. Bess, Jr.	Piedmont	William H. Boone	Keyser	2nd Wed.
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Raleigh	B. B. Richmond	Beckley	Richard G. Starr	Beckley	3rd Thurs.
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Taylor	K. H. Trippett	Grafton	Paul P. Warden	Grafton	Last Thurs.
Wetzel	Lemayne Coffield	N. Martinsville	Charles P. Watson	New Martinsville	Monthly
Wyoming	Jorge Piedra	Mullens	Ross E. Newman	Mullens	Quarterly

APRIL
1964

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CONTENTS

Scientific Articles

Changing Concepts of Angiography—Joseph L. Curry, M. D., Willard J. Howland, Jr., M. D., Andrew K. Butler, M. D., Charles T. Lenton, Jr., M. D., and Zoltan Szalontay, M. D. 87

Duodenal Ulcer and the Success of Therapy—J. C. Handelsman, M. D. 92

Current Management of Coronary Heart Disease—James W. Woods, M. D. 97

Special Article

The History of E.E.N.T. Practice in West Virginia—William F. Beckner, M. D. 100

The President's Page

The Role of Medicine in a Changing Society—Charles L. Goodhand, M. D., President, West Virginia State Medical Association 102

Editorial

Acclimatization to Altitude 103
Needed: Rural Health Council 104

General News

Two More Speakers Added to Annual Meeting Program 105
Large Delegation Attends Rural Health Conference 106
Report of Compensation Sub-Committee 108
AAGP Scientific Assembly in Atlantic City 110
ACS Meeting at The Greenbrier 112

Special Departments

WVU Medical Center News xxiv
The Month in Washington xxvi
Obituaries xxviii
County Societies xxx
The Woman's Auxiliary xxxiii
Book Reviews xxxvi
Directory of Physicians in Limited Practice xli
Index to Advertisers xliv

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By MARY ELLEN AVERY, A.B., M.D., Assistant Professor of Pediatrics, Johns Hopkins School of Medicine; Pediatrician-in-charge, Newborn Nurseries, Johns Hopkins Hospital. About 225 pages, 6⅛" x 9¼", illustrated. About $7.50.

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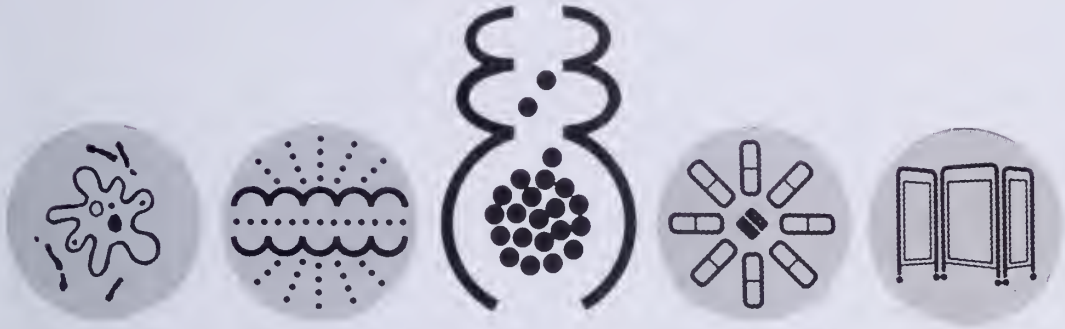

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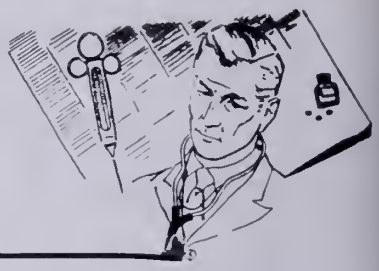
Research in the Service of Medicine SEARLE

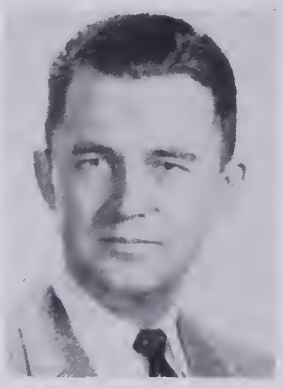
WVU Medical Center
—News—



Two members of the faculty of the West Virginia University School of Medicine have been elected to membership in the Society of University Surgeons.

Dr. Byron M. Bloor, Professor and Chairman of the Division of Neurosurgery, and Dr. Alvin L. Watne, Associate Professor of Surgery, were elected during the Society's annual meeting at Los Angeles in February.

Byron M. Bloor, M. D.



Alvin L. Watne, M. D.

Only 20 new members are chosen each year from the 86 medical schools in the United States. Two of the Society's purposes are to conduct new scientific research and to help solve the problems of undergraduate and graduate education in surgery.

Dr. Bernard Zimmermann, Professor and Chairman of Surgery, and Dr. Herbert E. Warden, Professor of Surgery, also are members of the Society.

Dr. Moran Presents Paper in Los Angeles

Dr. Walter H. Moran, Jr., Assistant Professor of Surgery, also attended the meeting and presented a paper on "The Relationship of Antidiuretic Hormone Secretion to Surgical Stress."

Doctor Moran was the senior author of the paper on research conducted at the School of Medicine into body responses during surgery. Co-authors were Drs. Frederick W. Miltenberger and Wihbi A. Shu'ayb, surgical residents, and Dr. Bernard Zimmermann, Professor and Chairman of the Department of Surgery.

Four Faculty Members Lecture in Parkersburg

Four members of the WVU School of Medicine faculty participated in a special one-day seminar on "The Heart of the Executive" at Parkersburg on January 31.

• **Compiled from material furnished by Howard Lewis, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

The four participants in the program sponsored by the Wood County Heart Association were Dr. Robert J. Marshall, Associate Professor of Medicine; Dr. David Z. Morgan, Instructor in Medicine; Dr. A. C. Edmundowicz, Assistant Professor of Medicine; and Dr. Victor E. Mazzoco, Resident in Medicine.

The program was directed toward the executive level and emphasized the preventive and rehabilitative aspects of coronary artery disease.

Grants for Cancer Research

Grants totaling $22,152 have been provided the West Virginia University School of Medicine by the American Cancer Society for research being conducted by Dr. Alvin L. Watne, Associate Professor of Surgery.

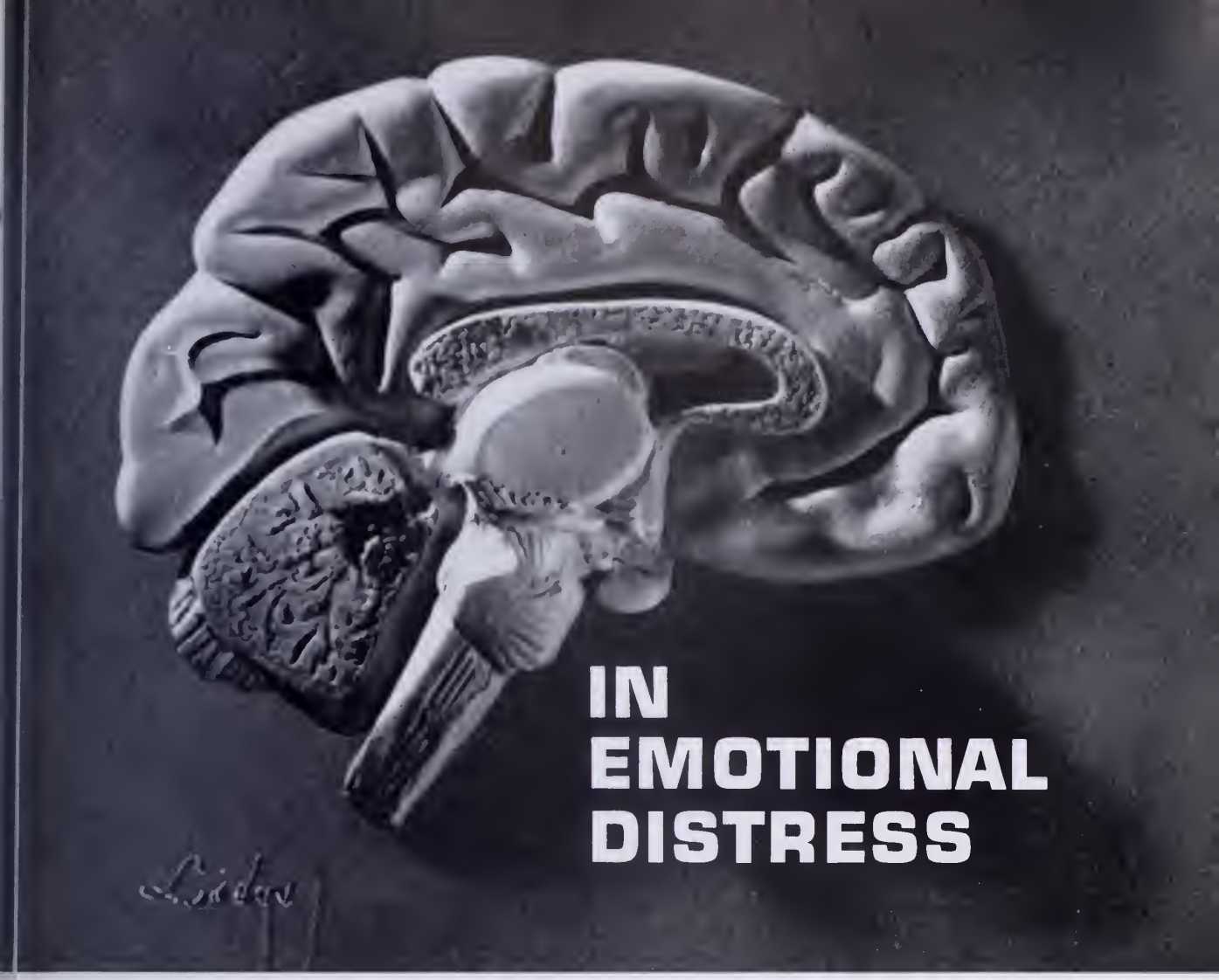
The grants cover two areas. One is for the study of factors affecting tumor growth and metastases in experimental animal tumors and methods of metastases prevention. The other is a study of host tumor cell relationship.

Two Pathologists Appointed

Drs. Ernest L. Abernathy and Regis W. Stinely, members of the staff at Washington Hospital in Washington, Pennsylvania, have been named Clinical Assistant Professors of Pathology at the WVU School of Medicine.

Doctor Abernathy is a native of Georgia and received his M. D. degree in 1947 from the Emory University School of Medicine. He taught pathology at the Emory and University of Cincinnati Schools of Medicine before entering the Medical Corps of the United States Army in 1953. He joined the Washington Hospital staff in 1955.

Doctor Stinely is a native of Johnstown, Pennsylvania, and received his M. D. degree in 1955 from the University of Pittsburgh School of Medicine. He served a residency in pathology at the West Penn Hospital in Pittsburgh prior to entering the Medical Corps of the United States Navy in 1958. He served as staff pathologist at the U. S. Naval Hospital in Oakland, California, and as chief of Laboratory Services at the U. S. Naval Hospital on Guam prior to his release from active duty in 1963.



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The Month in Washington

• From the Washington Office of the American Medical Association.

THE federal government is requiring assurances from sponsors of pending future Hill-Burton hospital projects that there will be no racial discrimination as to either patients or physicians.

Anthony J. Celebrezze, Secretary of Health, Education and Welfare, disclosed the new policy in testimony before the House Commerce Committee on legislation that would enlarge the Hill-Burton program and extend it for five more years. His testimony came a week after a Supreme Court decision that let stand an anti-segregation order against two Greensboro, North Carolina, hospitals.

Following the action by the Supreme Court, Celebrezze said, "I directed that the following additional steps be taken:

"(1) That we make permanent the earlier decision to approve no new applications under the "separate but equal" provision of the (Hill-Burton) law;

"(2) That we require a non-discrimination assurance in admittance from those pending projects previously approved on a "separate but equal" basis;

"(3) That we seek from all pending projects an assurance that there will be no discrimination on the basis of race, creed, or color in granting staff privileges; and

"(4) That the application forms to be used hereafter be amended to require all applicants whose application has not been finally approved, a non-discrimination assurance covering staff privileges and admissions, and that all portions and services of the facilities be made available without discrimination on account of race, creed or color."

Voluntary Implementation

Celebrezze also said that consideration was being given to calling a meeting of the leaders in organized medicine, in the hospital and related health fields, with a view toward implementing non-discrimination programs voluntarily. "I would hope that such a voluntary program would encompass not only Hill-Burton hospital facilities but all hospitals in the United States," he said.

The Supreme Court's "let stand" ruling foreshadowed a hospital desegregation drive thoughout the south. A spokesman for the National Association for the Advancement of Colored People, said hospital desegregation law suits were planned for a number of other southern cities. A spring trial already has been scheduled on a complaint against Grady Memorial Hospital in Atlanta, the largest public hospital there. Another suit involved a hospital in Newport News, Virginia.

The Supreme Court let stand a decision handed down Nov. 1, 1963, by the Fourth U. S. Circuit Court of Appeals which held that hospitals built with Hill-Burton funds could not practice racial segregation as to both doctors and patients despite the "separate but equal" provision in the Hill-Burton act of 1946. The Supreme Court issued only a brief order, with no explanatory opinion.

Sought Anti-Segregation Order

Eleven negro doctors, dentists and patients brought suit against the Wesley Long Community and Moses H. Cone Memorial hospitals in Greensboro federal district court in 1962. The negro litigants petitioned for an anti-segregation order and for elimination of the "separate but equal" provision in the law.

The issue was whether participation by the State or Federal government, or both, brings government into the picture sufficiently to invoke the protection to individuals guaranteed in the U.S. Constitution. The guarantee of "equal protection of the laws" laid down in the 14th amendment, and other constitutional rights, may be enforced only against governments, not against private individuals.

The district court at Greensboro dismissed the suit of the negroes but it was overruled by the circuit court of appeals which held that the degree of state and federal involvement is sufficient under the Hill-Burton Program to bring the hospitals within the framework of constitutional requirements. This opinion noted that the United States had appropriated more than $1.2 million to Cone Memorial and almost $2 million to Wesley Long. "The massive use of public funds and extensive state-federal sharing in the common plan are all relevant factors," the circuit court said.

At the time the suit was filed, Cone Memorial did not afford Negro doctors and dentists staff privileges and admitted only a few Negro patients. Long Hospital was completely segregated. Both are non-profit charitable corporations under North Carolina law. Later, Cone Hospital announced it would consider staff applications from Negroes.

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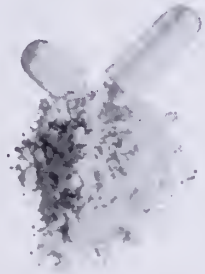

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Obituaries

HOWARD R. CREWS, M. D.

Dr. Howard R. Crews, 46, of Huntington, died on March 4 at a hospital in that city.

Doctor Crews, who had served as chief radiologist at St. Mary's Hospital in Huntington, was a native of Wyoming County. He was graduated from West Virginia University and received his M. D. degree in 1940 from the Tulane University School of Medicine.

He served an internship and residency at the Chesapeake and Ohio Hospital in Huntington, 1940-41. During World War II he served with the Medical Corps of the United States Army in the European Theatre of Operations.

Doctor Crews did postgraduate work in radiology at the Doctors Hospital in Washington, D. C., 1945-48, and was certified by the American Board of Radiology.

He was a member of the Cabell County Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by a son, Howard R. Crews, Jr., a student at West Virginia University; his mother, Mrs. H. R. Crews, and a brother, Edward Crews of Pineville; and two sisters, Katherine Crews of Pineville, and Mrs. E. A. Hatcher, Jr., of Logan.

DEAN LEONARD HOSMER, M. D.

Dr. Dean Leonard Hosmer, 63, of Bluefield, died on March 6 at a hospital in that city.

Doctor Hosmer, who was a native of Sanford, Maine, received his M. D. degree in 1928 from the University of Michigan Medical School.

He served an internship at the Maryland General Hospital in Baltimore, 1928-29, and then joined the staff of the Bluefield Sanitarium in 1930. He did postgraduate work in orthopedics at the Harvard and New York University Medical Colleges.

Doctor Hosmer was a member of the Mercer County Medical Society, West Virginia State Medical Association, Southern Medical Association and American Medical Association.

* * * *

WILMER G. OLIPHANT, M. D.

Dr. Wilmer G. Oliphant, 49, formerly of Burnwell and Morgantown, died on February 17 at his home in Knoxville, Tennessee.

Doctor Oliphant was born at Tamroy, West Virginia, on January 4, 1915. He attended the two-year School of Medicine at West Virginia University and received his M. D. degree in 1951 from the Medical College of Virginia.

He served an internship at Charleston General Hospital, 1951-52, and a residency in anesthesiology at the University of Tennessee Hospital in Knoxville, 1957-59.

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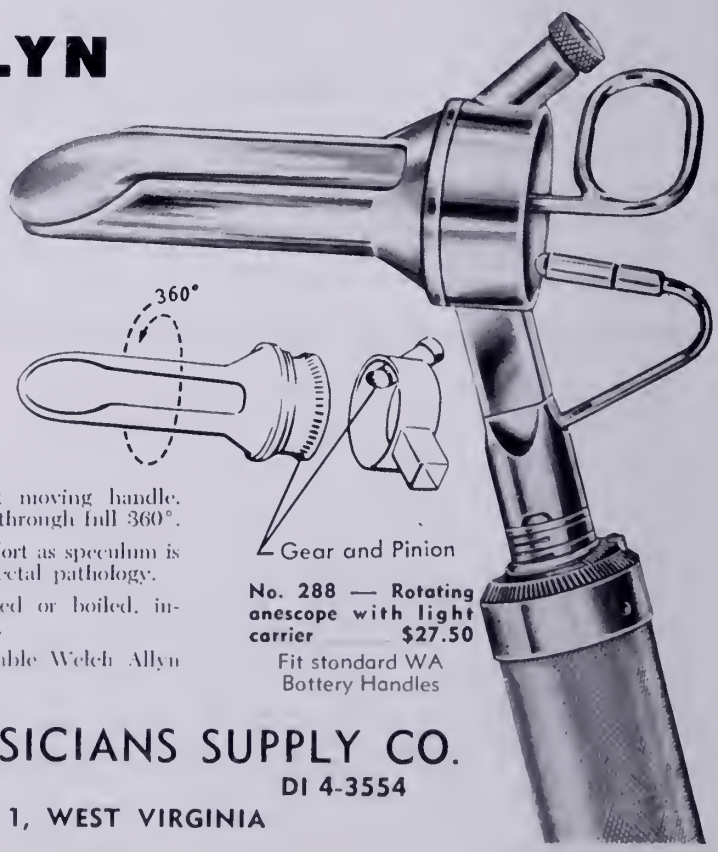

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Doctor Oliphant was a former member of the Kanawha Medical Society and the West Virginia State Medical Association.

* * * *

HORACE ALLEN WHISLER, M. D.

Dr. Horace Allen Whisler, 79, of Clarksburg, died on February 17 in a Charleston nursing home after an extended illness.

Doctor Whisler, who had practiced in the Clarksburg area for 54 years before his retirement in 1962, was graduated from the University of Maryland and received his M. D. degree in 1908 from the College of Physicians and Surgeons in Baltimore.

He took postgraduate work at the New York Postgraduate School of Medicine and the New York Eye and Ear Infirmary. During World War I, he served in the Medical Corps of the United States Army.

Doctor Whisler was an honorary life member of the Harrison County Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by two daughters, Mrs. Jeanne Call of Charleston, and Mrs. Ruth Robinson of Tucson, Arizona; and one son, Gordon Whisler of Whittier, California.

* * * *

RUFUS EMORY WOODALL, M. D

Dr. Rufus Emory Woodall, 74, of Charleston, died on March 6 at a hospital in that city after an extended illness.

Doctor Woodall was a native of Kanawha County. He received his M. D. degree in 1915 from the College of Physicians and Surgeons in Baltimore and was licensed to practice that same year in West Virginia.

During World War I he served as Assistant Division Surgeon with the 79th Division and was released with the rank of Captain.

He was an honorary life member of the Kanawha Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by a daughter, Mrs. Margaret Ann Gee of Charleston, and a son, Dr. Robert E. Woodall of Stanford, Kentucky.

FDA Setting Therapy Standards?

Certain aspects of the (warning) memorandum make one wonder how the Food and Drug Administration staff gathered its information. What is their evidence, for example, that topical corticosteroids are contraindicated in ocular tuberculosis? What is "purulent blepharitis"? If it exists, what is the evidence that topical corticosteroids are contraindicated in this condition? What is the evidence that purulent conjunctivitis is adversely affected by topical antibiotic-steroid combinations? If by any, by which ones? . . . If the FDA is attempting to set standards for therapy of eye diseases, would not a more scholarly approach be in order? Failing this, should not the memorandum be rescinded and replaced by a simple, general warning?—Archives of Ophthalmology.

OFFICERS OF COMPONENT SOCIETIES

Society	President		Secretary		Meetings
Barbour-Randolph-Tucker	Vernon E. Duckwall	Elkins	A. Kyle Bush	Philippi	3rd Thurs.
Boone	A. E. Glover	Madison	Harold H. Howell	Madison	2nd Wed.
Brooke	W. T. Booher, Jr.	Wellsburg	W. T. Booher, Sr.	Wellsburg	
Cabell	Clarence H. Boso	Huntington	W. L. Neal	Huntington	2nd Thurs.
Central West Virginia	Donald S. Groves	Summersville	R. L. Chamberlain	Buckhannon	As Scheduled
Eastern Panhandle	F. A. Hamilton, Jr.	Martinsburg	E. Andrew Zepp	Martinsburg	2nd Wed.
Fayette	Chuan H. Lee	Montgomery	D. Alene Blake	Oak Hill	1st Wed.
Greenbrier Valley	Harvey A. Martin	White Sul. Spgs.	Stuart T. Bray	White Sul. Spgs.	2nd Wed
Hancock	David H. Williams	Weirton	Ray S. Greco	Weirton	2nd Tues.
Harrison	Robert S. Wilson	Clarksburg	Richard K. Hanifan	Clarksburg	1st Thurs.
Kanawha	George L. Grubb	Charleston	Henry R. Gloss, Jr.	Charleston	2nd Tues.
Logan	George R. Mullins	Logan	Thomas P. Long	Man	2nd Wed.
Marion	James E. Wotring	Fairview	G. Thomas Evans	Fairmont	Last Tues.
Marshall	Kenneth J. Allen	Moundsville	J. W. Myers	Moundsville	Semi-Ann.
Mason	C. Leonard Brown	Pt. Pleasant	Richard L. Slack	Pt. Pleasant	Bi-Monthly
McDowell	John S. Cook	Welch	David J. Skewes	Coalwood	2nd Wed.
Mercer	John J. Mahood	Bluefield	J. Brookins Taylor	Bluefield	3rd Mon.
Mingo	Andrew H. Henderson	Williamson	Russell A. Salton	Williamson	2nd Wed.
Monongalia	Reginald Krause	Morgantown	W. E. King	Morgantown	1st Tues.
Ohio	Joseph L. Curry	Wheeling	A. J. Purpura	Wheeling	4th Tues.
Parkersburg Academy	Robert C. Lincicome	Parkersburg	Dwight P. Cruikshonk	Parkersburg	1st Thurs.
Potomac Valley	Robert W. Bess, Jr.	Piedmont	William H. Boone	Keyser	2nd Wed.
Preston	W. Parke Johnson, Jr.	Masontown	C. Y. Moser	Kingwood	4th Thurs.
Raleigh	B. B. Richmond	Beckley	Richard G. Starr	Beckley	3rd Thurs.
Summers	J. W. Stokes	Hinton	D. W. Ritter	Hinton	3rd Mon.
Taylor	K. H. Trippett	Grafton	Paul P. Warden	Grafton	Last Thurs.
Wetzel	Lemoyne Coffield	N. Martinsville	Charles P. Watson	New Martinsville	Monthly
Wyoming	Jorge Piedra	Mullens	Ross E. Newmon	Mullens	Quarterly

County Societies

CABELL

Dr. Emil L. Mantini of Morgantown was the guest speaker at the regular monthly meeting of the Cabell County Medical Society which was held at the Hotel Frederick in Huntington on February 13.

Doctor Mantini, who is a resident in surgery at the West Virginia University Hospital, presented a well organized and stimulating paper on "The Subclavian Steal Syndrome."

During the business meeting, Dr. Walter C. Swann was unanimously elected to honorary life membership in the Society. Dr. John M. Bobbitt, chairman of the Committee on Public Relations, urged the Society to launch a publicity campaign against the King-Anderson bill.

The Society also passed unanimously a motion commending Dr. J. Bernard Poindexter for his outstanding work during the 1964 session of the Legislature. Doctor Poindexter, a practicing dentist, has served several terms as a Delegate from Cabell County.

Dr. C. H. Boso, the president, presided at the meeting which was attended by 49 members and guests.—W. L. Neal, M. D., Secretary.

MARION

Dr. Boylston D. Smith, Jr., of Clarksburg, was the guest speaker at the regular monthly meeting of the Marion County Medical Society which was held at the Fairmont Hotel in Fairmont on February 25.

Doctor Smith, who serves as Clinical Instructor in Psychiatry at the West Virginia University School of Medicine, discussed "What We Can Do About Mental Health."

His talk was directed toward what action a community can take to improve the emotional atmosphere in homes, schools and the community in general.

* * * *

McDOWELL

The regular monthly meeting of the McDowell County Medical Society was held at Grace Hospital in Welch on February 12.

Dr. Robert E. Dye presented a paper on fatty liver and a film on diabetes also was shown.

During the business meeting, there was discussion concerning the King-Anderson Bill and the Society voted to insert several ads in the daily newspaper.

Dr. John S. Cook, the president, presided at the meeting which was attended by 18 physicians.—David J. Skewes, Secretary.

* * * *

MERCER

The annual joint meeting of the Mercer County Medical Society and the Mercer County Bar Associa-

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tion was held at the West Virginian Hotel in Bluefield on January 20.

The guest speaker was Mr. Craig Spangenberg of Cleveland, Ohio. Mr. Spangenberg, a prominent trial lawyer, spoke on "Medico-Legal, War and Peace."—J. Brookins Taylor, M. D., Secretary.

* * * *

MONONGALIA

The regular monthly meeting of the Monongalia County Medical Society was held in Morgantown on January 7.

Dr. R. F. Krause, the president, presided at the business meeting. Dr. Carl E. Johnson presented a detailed committee report on the study of a full-time county health director.

The Society approved a motion calling for the appointment of a certified full-time health director after hearing a summary presented by several members.

Twenty dentists were guests at the regular monthly meeting of the Monongalia County Medical Society which was held in Morgantown on February 4.

Edward G. Sippel, a representative of Bache & Co., of New York, was the guest speaker. He discussed the Keogh Bill as it pertains to retirement benefits for the self employed.

Dr. R. F. Krause, the president, presided at the business meeting. Drs. Margaret I. Stemple, Janet H. Strader and A. C. Edmundowicz were elected unanimously as new members of the Society and Dr. Chae

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G. J. Pentecost, M. D.

Orthopedic Surgery:
C. B. Buffington, M D.
G. B. Krivchenia, M. D.

Thorocic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics ond Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.

Urology:
Richard D. Gill, M. D.

Neurologicol Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

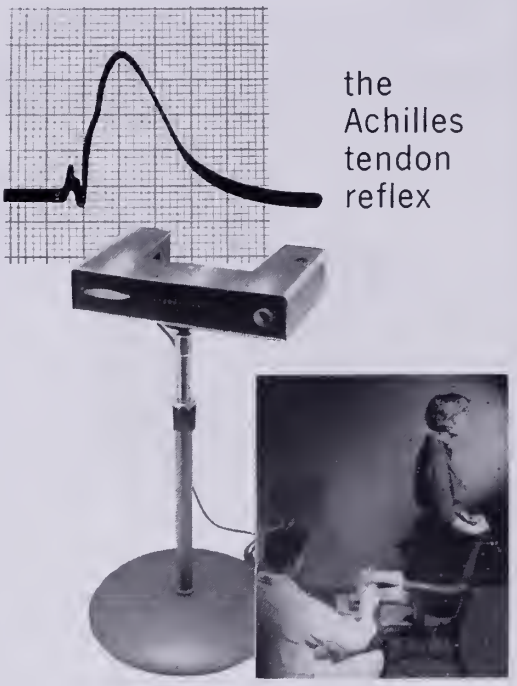
Psychiotry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Loborotories:
Nancy Fondriest, M. T.

Technologists:
Electrocardiography:
Patricia Pastor, R. N.
Electroencephalography:
JoAnn Hastings
Roentgenology:
Evelyn Forester, R. T.

Business Monager:
Lester L. Cline



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Han Chang as a transfer from the Logan County Medical Society.

A letter was read from State Director of Health Dr. N. H. Dyer expressing his department's willingness to cooperate fully in obtaining an approved full-time health officer for Monongalia County.

Dr. George A. Curry, chairman of the Society's "Operation Hometown" campaign, discussed the status of the King-Anderson bill in Congress and the need for continued opposition to this type of legislation.—William E. King, M. D., Secretary.

New Association Members

Dr. Albin Adolph Galuszka, 356 Washington Avenue, Clarksburg (Harrison). Doctor Galuszka, a native of Chicopee Falls, Massachusetts, was graduated from Tufts College and received his M. D. degree in 1942 from Tufts University School of Medicine. He interned at the U.S. Naval Hospital in Newport, Rhode Island, and served residencies at hospitals in Seattle, Philadelphia and New York. He served for 20 years with the Medical Corps of the United States Navy and was retired in 1962 with the rank of Captain. He is a Diplomate of the American Board of Urology and formerly served as Chief of Urology at the U.S. Naval Hospital in Bethesda, Maryland.

* * * *

Dr. Louis W. Groves, Jr., 4 School Street, Richwood (Central West Virginia). Doctor Groves was born in Richwood and was graduated from West Virginia University. He received his M. D. degree in 1962 from the WVU School of Medicine, and served an internship at Memorial Hospital in Charleston, 1962-63. He is engaged in general practice.

* * * *

Dr. Daniel E. Hendricks, 407 W. King Street, Martinsburg (Eastern Panhandle). Doctor Hendricks, a native of Jefferson County, attend the two-year WVU School of Medicine and received his M. D. degree in 1957 from the Medical College of Virginia. He interned at Bellevue Hospital in New York City, 1957-58, and served a residency at the Medical College of Virginia Hospital, 1958-62. His specialty is general surgery.

* * * *

Dr. Edwin J. Humphrey, II, 418 11th Street, Huntington (Cabell). Doctor Humphrey was born in Huntington and was graduated from Marshall University. He received his M. D. degree in 1957 from the Medical College of Virginia, and served an internship and residency at DePaul Hospital in Norfolk, Virginia, 1957-61. He served for two years in the Medical Corps of the United States Navy, and his specialty is obstetrics and gynecology.

* * * *

Dr. George B. Irons, Jr., 713 West Virginia Building, Huntington (Cabell). Doctor Irons, a native of Lewisburg, was graduated from West Virginia University and received his M. D. degree in 1958 from the Medical College of Virginia. He interned and served a residency at the Medical College of Virginia Hospital, 1958-63, and his specialty is general surgery.

Woman's Auxiliary

to the

WEST VIRGINIA STATE MEDICAL ASSOCIATION

President: Mrs. Pat A. Tuckwiller, Charleston
President Elect: Mrs. George A. Curry, Morgantown
First Vice President: Mrs. Lysle T. Veach, Petersburg
Second Vice President: Mrs. Charles S. Harrison Clarksburg
Third Vice President: Mrs. Joe N. Jarrett, Oak Hill
Fourth Vice President: Mrs. Wilson P. Smith, Huntington
Treasurer: Mrs. Grover C. Hedrick, Jr., Beckley
Recording Secretary: Mrs. Robert J. Tchou, Williamson
Corresponding Secretary: Mrs. James T. Spencer, Charleston
Parliamentarian: Mrs. John W. Hash, Charleston

CABELL

A "Bonnet Buffet," featuring new spring hats, was presented by the Woman's Auxiliary to the Cabell County Medical Society at the Huntington Woman's Club on March 13.

Proceeds were donated to the AMA-ERF and designated for the West Virginia University School of Medicine.

Mrs. Pat A. Tuckwiller of Charleston, President of the Woman's Auxiliary to the West Virginia State Medical Association, was a special guest at the affair.

Radiology:
KARL J. MYERS, M. D.

Pathology:
S. D. WU, M. D.

Surgery:
HU C. MYERS, M. D.
A. KYLE BUSH, M. D.

Gynecology and Obstetrics:
RAYMOND W. CRONLUND, M. D.

Internal Medicine:
JOHN E. LENOX, M. D.
J. L. RITTMEYER, M. D.
ERNEST G. GUY, M. D.

Pediatrics:
CORA C. LENOX, M. D.

Dentistry:
GLENN B. POLING, D. D. S.

Anesthesiology:
G. E. HARTLE, M. D.

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HARRISON

Members of the Woman's Auxiliary to the Harrison County Medical Society honored their husbands with a dinner-dance in observance of "Doctors Day" at the Clarksburg Country Club on March 7.

Mrs. Paul E. Gordon, the president, welcomed the physicians, and Dr. Robert S. Wilson, president of the Society, gave the response.

Mrs. E. Burl Randolph, the social chairman, was in charge of arrangements.—Mrs. Karl A. Dillinger, Press and Publicity.

* * * *

KANAWHA

Dr. Thomas S. Knapp, Charleston psychiatrist, was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Kanawha Medical Society which was held at the Charleston Press Club on February 11.

Doctor Knapp discussed "Suicide—Acute and Chronic." He said that suicide ranks seventh in the causes of death in West Virginia and that suicide is attempted every 60 seconds in the United States.

He defined acute suicide as very dramatic and chronic as perhaps smoking against the advice of a physician or overeating when on a restricted diet.

The Auxiliary voted contributions to six local and State projects from its special project fund. Receiving money were the AMA-ERF, earmarked for the West Virginia University School of Medicine; the Morris Harvey College School of Nursing; the West Virginia Association of Mental Health, to be used locally; the Health Careers Scholarship Fund of the Woman's Auxiliary to the State Medical Association; the Hearing Testing Program carried on by the Auxiliary in Kanawha County Schools; and Camp Galahad.

Dr. George L. Grubb was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Kanawha Medical Society which was held at the Charleston Woman's Club on March 10.

Doctor Grubb, president of the Kanawha Medical Society and an authority on the Dead Sea Scrolls, discussed the implications of this most important historical discovery.—Mrs. James H. Walker, Publicity Chairman.

* * * *

MARION

Dr. William A. Ehrgott was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Marion County Medical Society which was held at the Fairmont Hotel in Fairmont on February 25.

Doctor Ehrgott, pathologist at the Fairmont General Hospital, discussed heart and blood vessel diseases after presenting two films on these subjects.

Mrs. Ehrgott, the president, presided at the business session. Fifty-dollars derived from a benefit bridge party was donated to AMA-ERF and earmarked for the West Virginia University School of Medicine.

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MERCER

"The Toadstools Millionaires" was the title of the book reviewed by Mrs. Edward J. McQuail, Jr., at the February meeting of the Woman's Auxiliary to the Mercer County Medical Society which was held at the home of Dr. and Mrs. David F. Bell, Jr., in Bluefield.

The book deals with the rise of patent medicines from their beginning through the first Federal Food and Drug Act, which was signed by President Theodore Roosevelt in June, 1906. Mrs. McQuail stated that the 1860's brought a new field of medicine to the United States and that medical quackery was greatly influenced by the Civil War. The volume, written by James Arthur Long, is an excellent treatise on the subject of patent medicine and was presented in a most delightful manner by the speaker.

Mrs. J. E. Blaydes, Jr., the president, welcomed members and guests to the morning coffee and presided at the business meeting. Mrs. Bell, the hostess, was assisted by Mesdames P. R. Fox, W. F. Hillier, William M. Bruch and A. C. Van Reenan.—Mrs. Richard O. Rogers, Jr., Press and Publicity.

* * * *

OHIO

Rabbi Martin Siegel of Wheeling was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Ohio County Medical Society which was held at the Fort Henry Club in Wheeling on February 25.

Mrs. Herbert G. Dickie, Jr., the president, presided at the business meeting. Hostesses for the luncheon meeting were Mrs. Edward N. Pell, chairman, and Mesdames W. E. McNamara, William J. Steger, Bradford McCuskey and James A. Jacob.

Grant to Study Teaching Methods Offered by Heart Association

Applications are now being accepted by the American Heart Association for its 1964-65 Associate in Research in Medical Education Award.

The award is designed to stimulate careers in the field of postgraduate medical education and the program includes training in a medical school's department of research in medical education and participation in pilot projects in continuing education being undertaken by the Heart Association.

Applicants must have an M. D., Ph.D., Sc. D., degree or its equivalent and be citizens of the United States or Canada. To meet the needs of candidates, the stipend will be determined when applications are reviewed. Applications may be made through the West Virginia Heart Association, 759 West Washington Street, Charleston, West Virginia 25302.

When a man buys a new hat, he wants one just like the one he has had before. But a woman isn't that way.—E. W. Howe.

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Book Reviews

HYPOXIA—By Edward J. Van Liere, M. D., Ph.D., and J. Clifford Stickney, Ph.D., Chicago: The University of Chicago Press. 1963. Pp. 432. Price $8.75.

At the outbreak of World War II Doctor Van Liere published a very important monograph entitled "Anoxia—Its Effects on the Body." This became a valuable source book for the large number of research workers whose efforts were directed to the problems occasioned by high altitude flight.

As a consequence of the intense effort brought on by the war, rapid strides were made in understanding the physiology of oxygen want. Many of the physiologists who conducted this research during the war devoted their immediate postwar efforts to further elucidation of the problems. The present volume is, in recognition of an explosion of knowledge in this field, not merely a second edition of its predecessor; it is an entirely new book.

The term "anoxia" was at one time used to describe all conditions involving a reduced amount of oxygen in the body. Technically, however, the term means "without oxygen" and hence is incompatible with life. In the last several years there has been a movement to replace the unphysiologic term "anoxia" with "hypoxia," which literally means *reduced* oxygen. Perhaps in emphasis of this newer terminology, the term has become a rubric in the hands of the authors and appears in the chapter headings in seventeen of the nineteen chapters.

Again a valuable service has been rendered by pulling together the far-flung literature on this subject. While the problems of flight appear to be changing—in outer space equipment failure will result in fulminating anoxia—the need for knowledge regarding the physiological effects of reduced oxygen is not lessening. The last decade has witnessed the multiple conquest of Mount Everest and an intensification of assaults on other high peaks. An inevitable consequence of world population increase will be increased habitation of inhospitable higher altitudes. This new, highly

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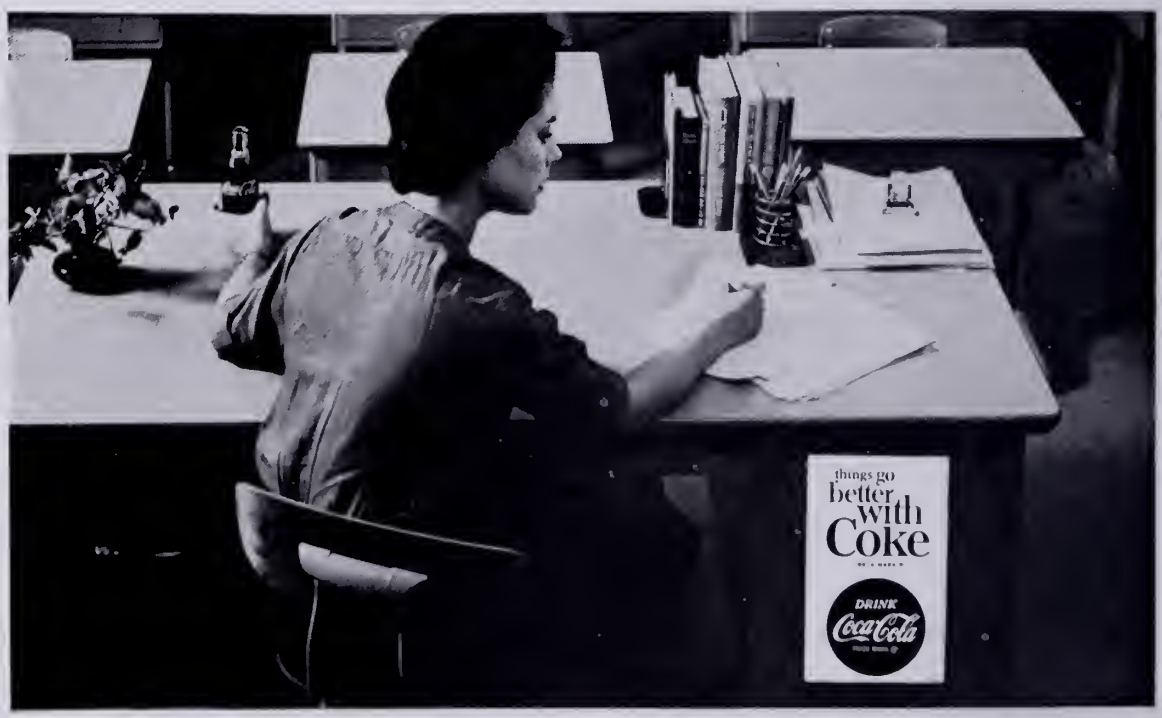

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authoritative coverage of the subject is a worthy successor to its valuable predecessor.—Kenneth E. Penrod, Ph. D.

CIBA FOUNDATION SYMPOSIUM ON LYSOSOMES—Edited by A. V. S. deReuck, M.Sc., D.I.C., A.R.C.S., and Margaret P. Cameron, M.A. Pages, 446 with illustrations. Little, Brown and Company, Boston, Massachusetts. 1964. Price $11.50

The electron microscope has enabled the cytologist to recognize the sophisticated architectural integrity, diversity and interrelationships of the internal milieu of cells. This has proved a tremendous impetus to modern biology to progress from a predominantly descriptive science to a science whose primary objective is to understand activities, functions and mechanisms and the correlation of these with the structural environment in which they occur. These developments have led to great interest in subcellular structural units.

The recognition of the lysosomes adds a new and interesting particle to this cellular architectural complex. The lysosomes represent a group of cytoplasmic entities containing primarily hydrolytic enzymes. These particles were first described by de Duve in 1955. This volume contains a collection of papers from a Ciba Symposium organized to honor Professor de Duve and to illustrate the importance of his work.

The book is divided into four sections representing the four days of the symposium. The general topics discussed, primarily by European investigators, include general properties of lysosomes, lysosomes and endocytosis, lysosomes and development processes and, finally, lysosomes and pathological cell damage. The extensive discussion which followed each paper and the general discussion at the end of the symposium are also included. This discussion, as usual, represents a most valuable and stimulating portion of a Ciba Symposium Volume.

The book provides a thorough examination and description of the functional activities of lysosomes, an indication of their ubiquitous distribution in animal cells, and a broad picture of the relationship of their structure and function to pathological conditions. The relationship of lysosomes to immunological phenomena, in terms of the mechanism by which these structures distinguish between self and non-self, is considered also.

Each paper is followed by an extensive bibliography. There is no general bibliography. The author index incudes only participants and contributors. There is a good, quite inclusive, subject index.

The book can be read and enjoyed by physicians and biological scientists who have an interest in intracellular structure and physiology. The outstanding contributions to almost all of the discussion periods by Professor Alex Novikoff are in themselves a delightful example of the enthusiastic functioning and breadth of an excellent scientific mind.—William T. Burke, Ph.D.

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Vol. 60 No. 5

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CONTENTS

Scientific Articles

Brain Abscess in Cyanotic Heart Disease—W. Scott Bowie, A. B., E. Lyle Gage, Jr., A. B., E. Lyle Gage, M. D., and Russell V. Lucas, Jr., M. D. 113

Intra-Epithelial Carcinoma of the Cervix and Pregnancy—Joseph C. Parker, M. D. 120

Diospyrobezoar—George E. Farrell, M. D., and Robert G. Shirey, M. D. 123

Occupational and Household Allergy Due to Inhalants—Macy I. Levine, M. D. 126

The President's Page

Guest Author, Mrs. Pat A. Tuckwiller of Charleston, President of the Woman's Auxiliary to the West Virginia State Medical Association 130

Editorial

Werewolves and Medicine 131

Resistance to Hypoxia 132

Lo, The Poor Doctor—He Can't Say 'No' 133

General News

Speakers at 97th Annual Meeting 134

AMA President Elect Honor Guest 135

GP Meeting in Charleston 136

Dr. Cunningham Still Going Strong 137

Public Health Meeting 139

Symposium on Pediatrics 140

Special Departments

WVU Medical Center News xxii

The Month in Washington xxiv

Obituaries xxvi

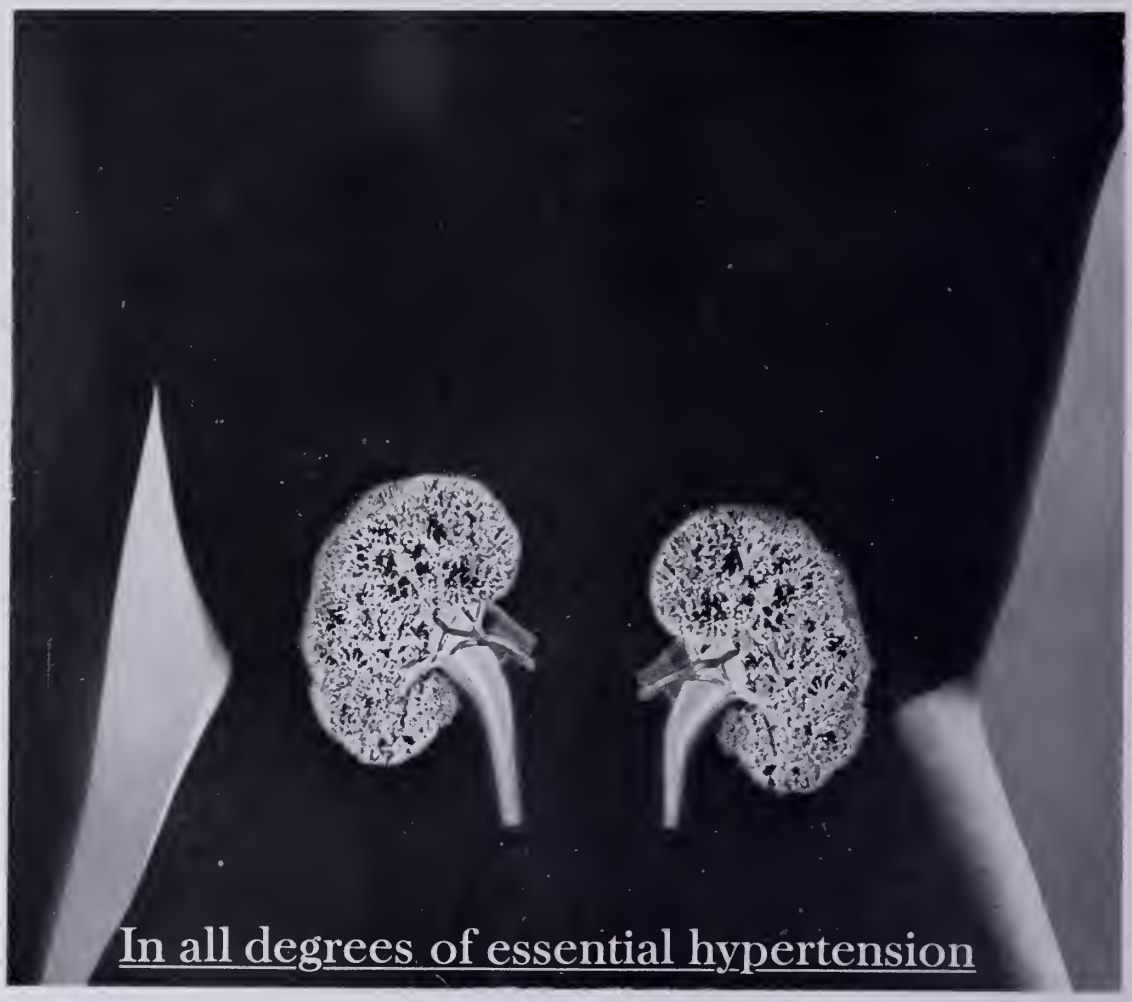
County Societies xxviii

The Woman's Auxiliary xxxii

Book Reviews xxxiii

Directory of Physicians in Limited Practice xli

Index to Advertisers xliv



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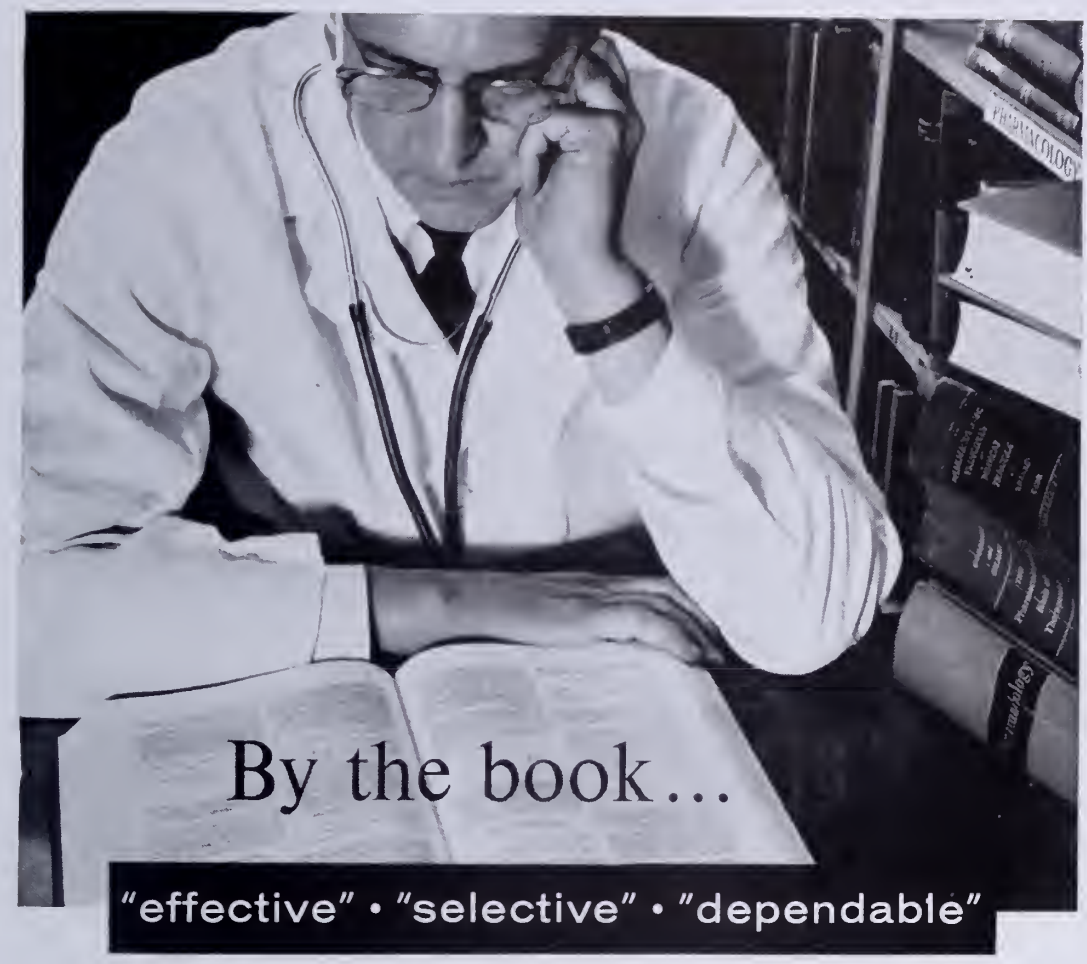

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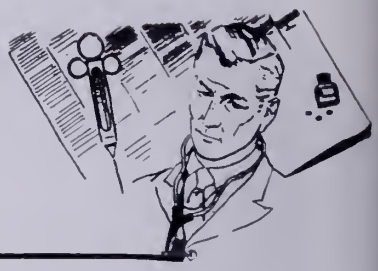

THIRTY-THREE of the 41 students comprising the third class scheduled to receive M. D. degrees at the West Virginia University School of Medicine received their first choice internship appointments.

Dean Clark K. Sleeth said 15 graduates will enter internship programs in West Virginia hospitals while two will go into military hospitals. The remaining 24 are widely distributed over the United States.

Charleston Memorial and Cabell-Huntington Hospitals will receive six interns each and three others will begin their year of training at the West Virginia University Hospital in Morgantown on July 1.

The WVU School of Medicine graduated its first class of 15 students in 1962. Forty-three students received M. D. degrees in 1963. In future years, classes will number about 60 students.

A list of the students, their home towns and internships accepted follows:

Cabell-Huntington Hospital—Nazem Abraham, Huntington; Tommy Joe Altizer, Mallory, Logan County; George R. Baise, Huntington; Harry Glenn Buchanan, Gilbert; Donald G. Klinestiver, Keyser; and James A. Lilly, Huntington.

Charleston Memorial Hospital—Spencer L. Bivens, Charleston; Thomas O. Dotson, Summersville; James M. Heaster, South Charleston; Karl V. Metz, Morgantown; Ernest G. Sayfie, Charleston; and James L. Schmidt, Morgantown.

West Virginia University Hospital—Walter S. Bowie, Morgantown; Mrs. Susan Shaw Gustke, New Cumberland; and William A. Morrison, Terra Alta.

Charlotte Memorial Hospital, Charlotte, North Carolina—Joseph A. Barta, Jr., Anawalt.

Los Angeles County Hospital, Los Angeles, California—Michael D. Bear, Fairmont.

Bronx Municipal Center, New York City—Thomas E. Carter, Bluefield.

Albert Einstein Medical Center, Philadelphia, Pennsylvania—John N. Chokatos, Clarksburg.

State University of Iowa Hospital, Iowa City, Iowa —William J. Echols, Richwood.

Harris Hospital, Fort Worth, Texas—Louis A. Fabian, Monongah; and Paul V. Watson, Huntington.

Medical College of Virginia, Richmond, Virginia—E. Lyle Gage, Jr., Bluefield; and Roger E. King, Morgantown.

Ancker Hosiptal, St. Paul, Minnesota—Richard H. Garretson, Huntington.

• **Compiled from material furnished by Howard Lewis, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

Scott Air Force Base Hospital, Belleville, Illinois—William J. Henshaw, Dunbar.

Walter Reed Army Hospital, Washington, D. C.—David R. Hobbs, Morgantown.

Lewis Gale Hospital, Roanoke, Virginia—Louis M. Judy, Morgantown; and John S. Palkot, Morgantown.

Akron City Hospital, Akron, Ohio—John A. Karnoupakis, Weirton; Thomas E. Richardson, Lewisburg; Edward J. Shahady, Fairmont; and James E. Wilkerson, Whitesville.

Allegheny General Hospital, Pittsburgh—Ruth E. Lemley, Fairview; and Antonio S. Licata, Weirton.

King County Hospital, Seattle, Washington—Bernard Mullen, Seattle, Washington.

North Carolina Baptist Hospital, Winston-Salem, North Carolina—Benjamin L. Plybon, Iaeger.

University of Chicago Clinics, Chicago—Paul H. Price, Morgantown.

University of Virginia Hospital, Charlottesville, Virginia—Joseph J. Renn, III, Martinsburg.

St. John's Hospital, Tulsa, Oklahoma—Donald E. Southern, Williamson.

Ben Taub Hospital, Houston, Texas—Charles V. Stewart, Jr., Mullens.

Attends Research Meeting

Dr. Kenneth E. Penrod, Vice President of WVU in charge of the Medical Center, attended a one-day conference on administration of research programs in colleges and universities which was held at the University of Michigan in Ann Arbor on March 10.

The purpose of the meeting was to bring together into small seminar groups some of the top administrators and research personnel from throughout the United States.

Participants included presidents, vice presidents, chancellors, deans, coordinators and directors of research programs from universities and other academic institutions which have substantial research programs in progress. An objective of the conference was to exchange ideas on problems and better methods of administrative direction of research programs.

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE American Medical Association has recommended to Congress that modernization of existing hospital facilities, especially in urban centers, be emphasized in the Hill-Burton hospital construction program. An AMA spokesman told the House Commerce Committee that a 1956 study indicated that about one-half of the nation's hospitals needed about $1 billion worth of modernization.

The committee was considering a five-year extension of the Hill-Burton program. The AMA supported the legislation but recommended changes in some of its provisions. The AMA concurred with the provision that would combine the various types of chronic disease hospitals and nursing homes into one category called "long term care facilities."

The AMA also supported the principle of federal guarantee of mortgages financing the cost of construction or modernization of a private nonprofit hospital or other specified medical facility, or proprietary nursing home.

"The use of the guaranteed mortgage mechanism offers an incentive to local nonprofit organizations to construct and improve needed medical facilities," the AMA said.

The AMA opposed a provision that would transfer to the Department of Health, Education and Welfare the Federal Housing Administration program of insured loans for construction of proprietary nursing homes.

The AMA also testified that "diagnostic and treatment centers" should be deleted as facilities eligible to participate in the Hill-Burton program. "There is little evidence of demand for these facilities since their inclusion in 1954," the AMA said. "Moreover, the definition of the term 'diagnostic or treatment center' is vague and confusing."

The AMA urged that the traditional local determination of need and local administration of the Hill-Burton program be continued. "The success enjoyed by the program testifies to the effectiveness of this approach," the AMA said. "The Association further urges that area-wide planning for hospitals and related health facilities remain on a voluntary basis . . . It is our belief that the success of each project would be enhanced if the efforts of the local agency and the local medical society could be joined when planning the location or improvement of facilities."

Funds Sought for Nursing Program

The Administration asked Congress to authorize a five-year, $260 million plan of federal aid designed to increase the number of nurses in the United States. The plan called for federal grants and loans for construction of nursing schools and training of nurses.

The American Medical Association approved in principle the construction provision but opposed loans and scholarships for nursing students.

Under the Administration plan, a total of $110 million would be spent over a four-year period on grants to construct new schools of nursing and to replace and expand existing schools. Another major feature of the bill encompassing the plan calls for spending $85 million over five years on loans to nursing students. A "forgiveness feature" would apply to 60 per cent of the loan.

To improve nurse training and service, project grants totaling $58.8 million would be allocated over five years to public and nonprofit agencies. Other funds would be spent on planning grants to help states develop nursing programs and a limited undergraduate scholarship program.

Boisfeuillet Jones, Special Assistant to the Secretary of Health, Education and Welfare, told a House Commerce Subcommittee that it was the hope of the Administration that through passage of the bill the total number of nurses in the country—presently estimated at 550,000—would increase to 680,000 by 1970.

Encouraging Report on Leukemia

The National Cancer Institute has sent Congress an encouraging report on its battle against leukemia. It asked for funds for "an all-out effort toward the goal of a cure."

In testimony made public by a House Appropriations Subcommittee, Institute Director Kenneth M. Endicott said there had been a great increase in the number of children in which it was possible to arrest the disease, at least temporarily.

He told the Subcommittee that improved treatments had increased the remission rate for children with acute leukemia to about 90 per cent and had "dramatically increased the periods of their remissions and consequently their life expectancy."

Dr. Endicott said the Institute, an arm of the Government's National Institutes of Health, had more than 60 children in its study groups who had survived more than five years after being treated with drugs.

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Obituaries

CHARLES RANDOLPH HUGHES, M. D.

Dr. Charles Randolph Hughes, 72, of Bluefield, died at a hospital in that city on March 14.

Doctor Hughes was born at Callao, Virginia, on April 3, 1891, son of the late Z. E. and Mary Elizabeth Hughes. He was graduated from Farnham Academy at Farnham, Virginia, and received his M. D. degree in 1917 from the Medical College of Virginia.

He served an internship at the City Hospital in Richmond, Virginia, 1916-17, and was in a residency at that hospital when he joined the Medical Corps of the United States Navy in 1918. He was licensed to practice in West Virginia in 1920 and was associated with the Pocahontas Fuel Company at Kimball and Eckman in McDowell County before moving his practice to Bluefield in 1942.

Doctor Hughes was an honorary life member of the Mercer County Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by a son, C. Randy Hughes of Bluefield; a daughter, Mrs. Harvey W. Turnage, Jr., of Atlanta, Georgia; a brother, Roland Hughes, and a sister, Mabel E. Hughes, both of Gallao.

IRA CONNOLLY, M. D.

Dr. Ira Connolly, 72, of Parkersburg, died at his home in that city on March 19.

Doctor Connolly, who had practiced more than 30 years in Parkersburg before illness forced his retirement in 1959, received his M. D. degree in 1915 from the Bennett Medical College in Chicago.

He was licensed to practice that same year in West Virginia and joined his father, the late Dr. Commodore Connolly, in practice at Richardson, Calhoun County. He also practiced at Leachtown in Wood County before moving to Parkersburg in 1923.

Doctor Connolly was an honorary life member of the Parkersburg Academy of Medicine, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by one son, Dr. Ira Connolly, Jr., of Parkersburg; two daughters, Mrs. Virginia Casto and Mrs. Olive Leeper; one half-sister, Mrs. Velma C. Brown; and four half-brothers, Dr. Randall Connolly, R. C. Connolly, Manfred Kelly and Uriah Kelly.

* * * *

MATTHEW FRANCIS C. ZUBAK, M. D.

Dr. Matthew Francis C. Zubak, 70, of Wheeling, died at his home in that city on April 3.

Doctor Zubak was born January 14, 1894, in Providence, Rhode Island, the son of Anthony and Sophia Zubak. He received his M. D. degree in 1916 from

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Jefferson Medical College in Philadelphia and served an internship at the Cooper Hospital in Camden, New Jersey, 1916-17.

He served as a surgeon in the Medical Corps of the United States Navy during World War I and was released with the rank of Lt. Commander.

Doctor Zubak took postgraduate work in ophthalmology and otolaryngology after World War I at the University of Pennsylvania Graduate School of Medicine. He opened his practice in Wheeling in 1922.

He was a member of the Ohio County Medical Society, West Virginia State Medical Association, American Academy of Opththalmology and Otolaryngology and the American Medical Association. He was certified in both ophthalmology and otolaryngology and was a Fellow of the American College of Surgeons.

Doctor Zubak served for many years as a member of the teaching staff at the Wheeling Hospital School of Nursing.

He served as Surgeon General of the Veterans of Foreign Wars, 1920-21.

Besides his widow, he is survived by two sons, Dr. Matthew F. C. Zubak, Jr., of Wheeling, and Richard S. Zubak of Hollywood, California; two brothers, Sigmund Zubak of Central Falls, Rhode Island, and Anthony Zubak of Providence, Rhode Island; and two sisters, Mrs. Cecelia Dunphy and Mrs. Edward D'Alfonso, both of Providence.

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County Societies

CABELL

Dr. George R. Callender, Jr., of Charleston, was the guest speaker at the regular monthly meeting of the Cabell County Medical Society which was held at the Hotel Frederick in Huntington on March 12.

Doctor Callender, who is Chairman of the Medical Economics Committee of the State Medical Association, discussed in detail the medical programs administered by the State Department of Welfare. There was considerable discussion and Doctor Callender pointed out that his committee welcomes comments and constructive criticism from the membership of the Association.

Drs. Fernando Dominquez, Wendell M. Burns and Thomas W. Nale were unanimously elected to membership in the Society.

Dr. Clarence H. Boso, the president, presided at the meeting which was attended by 43 members.

Dr. Kenneth E. Penrod of Morgantown was the guest speaker at the regular monthly meeting of the Cabell County Medical Society which was held at the Hotel Frederick in Huntington on April 9.

Doctor Penrod, who is Vice-President of West Virginia University in charge of the Medical Center, presented an interesting and encouraging progress report on the status of the Medical Center. He outlined the manner in which the operation of the Center is financed and stated that approximately 70 per cent of the patients now pay for their care, either privately or through a third party.

Doctor Penrod stated that the number of graduates will be increased from about 40 to 60 per year beginning in 1965. He said that approximately 305 of the 520 available hospital beds are now in use and that more will be opened as the number of students increase.

He said the research budget for the Medical Center is now $1.25 million annually, none of which is State funds.

Dr. Clarence H. Boso, the president, presided at the meeting which was attended by 39 members and guests. —W. L. Neal, M. D., Secretary.

* * * *

EASTERN PANHANDLE

Dr. Arthur T. Evans of Cincinnati was the guest speaker at the regular monthly meeting of the Eastern Panhandle Medical Society which was held in Martinsburg on March 18.

Doctor Evans, Director of the Division of Urology at the University of Cincinnati School of Medicine, presented a paper on "Curable Hypertension," utilizing numerous color slides and radiographs.—E. Walter Rice, M. D., Program Chairman.

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LOGAN

Dr. Charles L. Goodhand of Parkersburg was the guest speaker at the regular monthly meeting of the Logan County Medical Society which was held at the East End Barbecue in Logan on April 8.

Doctor Goodhand, President of the West Virginia State Medical Association, presented an interesting talk on "Organized Medicine Today." He was introduced by Dr. Lyle H. Boyea of Man, vice president of the Society.

Dr. Mark S. Spurlock presented a report on the Society's recent Sabin Oral Polio program in which about 30,000 persons received the vaccine at each of the three clinics held in Logan County.

* * * *

McDOWELL

Dr. James P. Thomas of Bluefield was the guest speaker at the regular monthly meeting of the McDowell County Medical Society which was held at the Stevens Clinic Hospital in Welch on March 11.

Doctor Thomas, who is a member of the Department of Surgery at the Bluefield Sanitarium, presented a paper on vascular pathology and surgery.

Dr. John S. Cook, the president, presided at the business meeting and Dr. Richard O. Gale presented a report of the District Review Committee.

The regular monthly meeting of the McDowell County Medical Society was held at Grace Hospital in Welch on April 8.

Dr. A. J. Villani presented a report on the Operation Hometown Committee and the Society voted to make a donation to Camp Kno-Koma.

Dr. Robert E. Dye showed a film on heart disease and pregnancy.

Dr. John S. Cook, the president, presided at the meeting which was attended by 13 members.—David J. Skewes, M. D., Secretary.

* * * *

MERCER

The Mercer County Medical Society held its regular monthly meeting at the West Virginian Hotel in Bluefield on February 17.

Dr. James P. Thomas of Bluefield was the speaker. He presented a most enlightening paper on advances in cardiovascular surgery.—J. Brookins Taylor, M. D., Secretary.

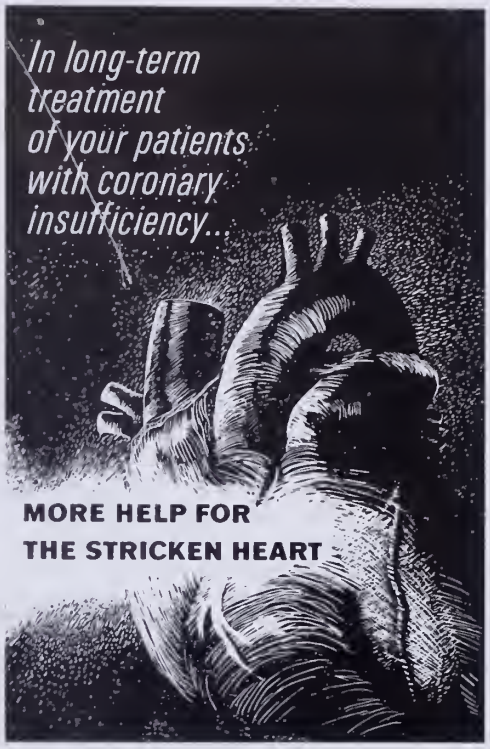
* * * *

PARKERSBURG ACADEMY

Dr. Charles E. Andrews of Morgantown was the guest speaker at the regular monthly meeting of the Parkersburg Academy of Medicine which was held at the American Legion Home in Parkersburg on March 5.

Doctor Andrews, Professor of Medicine at the West Virginia University School of Medicine, presented a paper on pulmonary diseases.

Dr. Robert C. Lincicome, the president, presided at the business meeting.—Dwight P. Cruikshank, M. D., Secretary.



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OFFICERS OF COMPONENT SOCIETIES

Society	President		Secretary		Meetings
Barbour-Randolph-Tucker	Vernon E. Duckwall	Elkins	A. Kyle Bush	Philippi	3rd Thurs.
Boone	A. E. Glover	Madison	Harold H. Howell	Madison	2nd Wed.
Brooke	W. T. Booher, Jr.	Wellsburg	W. T. Booher, Sr.	Wellsburg	
Cabell	Clarence H. Boso	Huntington	W. L. Neal	Huntington	2nd Thurs.
Central West Virginia	Donald S. Groves	Summersville	R. L. Chamberlain	Buckhannon	As Scheduled
Eastern Panhandle	F. A. Hamilton, Jr.	Martinsburg	E. Andrew Zepp	Martinsburg	2nd Wed
Fayette	Chuan H. Lee	Montgomery	D. Alene Blake	Oak Hill	1st Wed.
Greenbrier Valley	Harvey A. Martin	White Sul. Spgs.	Stuart T. Bray	White Sul. Spgs.	2nd Wed
Hancock	David H. Williams	Weirton	Roy S. Greco	Weirton	2nd Tues.
Harrison	Robert S. Wilson	Clarksburg	Richard K. Hanifan	Clarksburg	1st Thurs.
Kanawha	George L. Grubb	Charleston	Henry R. Glass, Jr.	Charleston	2nd Tues.
Logan	George R. Mullins	Logan	Thomas P. Long	Man	2nd Wed.
Marion	James E. Watring	Fairview	G. Thomas Evans	Fairmont	Last Tues.
Marshall	Kenneth J. Allen	Moundsville	J. W. Myers	Moundsville	Semi-Ann.
Mason	C. Leonard Brown	Pt. Pleasant	Richard L. Slack	Pt. Pleasant	Bi-Monthly
McDowell	John S. Cook	Welch	David J. Skewes	Coalwood	2nd Wed.
Mercer	John J. Mahood	Bluefield	J. Brookins Taylor	Bluefield	3rd Mon.
Mingo	Andrew H. Henderson	Williamson	Russell A. Salton	Williamson	2nd Wed.
Monongalia	Reginald Krause	Morgantown	W. E. King	Morgantown	1st Tues.
Ohio	Joseph L. Curry	Wheeling	A. J. Purpura	Wheeling	4th Tues.
Parkersburg Academy	Robert C. Lincicome	Parkersburg	Dwight P. Cruikshank	Parkersburg	1st Thurs.
Potomac Valley	Robert W. Bess, Jr.	Piedmont	William H. Boone	Keyser	2nd Wed
Preston	W. Parke Johnson, Jr.	Masontown	C. Y. Moser	Kingwood	4th Thurs.
Raleigh	B. B. Richmond	Beckley	Richard G. Starr	Beckley	3rd Thurs.
Summers	J. W. Stokes	Hinton	D. W. Ritter	Hinton	3rd Mon.
Taylor	K. H. Trippett	Grafton	Paul P. Warden	Grafton	Last Thurs.
Wetzel	Lemoyne Coffield	N. Martinsville	Charles P. Watson	New Martinsville	Monthly
Wyoming	Jorge Piedra	Mullens	Ross E. Newman	Mullens	Quarterly

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Orthopedic Surgery:
C. B. Buffington, M. D.
G. B. Krivchenia, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
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HARRISON

A joint meeting of the Harrison County Medical Society and the Woman's Auxiliary was held at the Clarksburg Country Club on April 2. Special guests were West Virginia University School of Medicine senior medical students and their wives.

Dr. Robert S. Wilson, president of the Society, welcomed members and guests and the response was given by Mr. W. Scott Bowie, president of the senior medical class. Dr. Lawrence B. Thrush discussed the facilities available both in the local hospitals and the community, and welcomed any future physicians to the Clarksburg area.

The dinner meeting was attended by 55 members and 23 guests.—Mrs. Karl A. Dillinger, Press and Publicity.

* * * *

MERCER

The regular monthly meeting of the Woman's Auxiliary to the Mercer County Medical Society was held at the Y Center in Bluefield on March 18.

Dr. John J. Mahood of Bluefield was the guest speaker. He discussed AMA-ERF and its success in providing loans to more than 11,500 medical students.

Mrs. J. E. Blaydes, Jr., the president, presided at the business meeting. Mrs. James E. McGee, Jr., the secretary, and Mrs. R. S. Gatherum, Jr., the treasurer, presented reports and Mrs. David F. Bell, Jr., read a letter of appreciation from Dr. Clark K. Sleeth, Dean of the West Virginia University School of Medicine, for the Auxiliary's recent contribution.

* * * *

McDOWELL

Members of the Woman's Auxiliary to the McDowell County Medical Society honored their husbands at a Doctor's Day dinner which was held at the Gary Country Club on April 1.

The Auxiliary also entertained the Future Medical Leaders of America at the annual tea which was held on April 8. More than 135 girls attended the tea.—Mrs. John H. Murry, Secretary.

Book Reviews

APPRAISAL OF CURRENT CONCEPTS OF ANESTHESIOLOGY—By John Adriani, M. D., Professor of Surgery, Tulane University School of Medicine, New Orleans, La., Clinical Professor of Surgery and Pharmacology, Louisiana State University School of Medicine, New Orleans, La.; Director, Department of Anesthesiology, Charity Hospital of Louisiana, New Orleans, La. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Missouri. 1964. Price $10.75.

A good book, like a good friend, is to be enjoyed and relied upon. This volume, like its predecessor, qualifies as a good book. The number of chapters remains at 45. The book has been enlarged and the contributors have handled several topics in more depth than was true previously.

Doctor Adriani's ability to set his thoughts down in a concise, readable, retainable manner is well known and is evident in his editing of this volume. In reading the book, one realizes that what is curernt for 1964 does not have to originate in 1963. Indeed, the chapter on heart sounds is most basic but includes enough recent material to make it worthy of repeating.

The volume will serve as a source of information on new agents and techniques used in anesthesia. Any practitioner, however, could read the chapters on

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JOHN E. LENOX, M. D.
J. L. RITTMEYER, M. D.
ERNEST G. GUY, M. D.

Pediatrics:
CORA C. LENOX, M. D.

Dentistry:
GLENN B. POLING, D. D. S.

Anesthesiology:
G. E. HARTLE, M. D.

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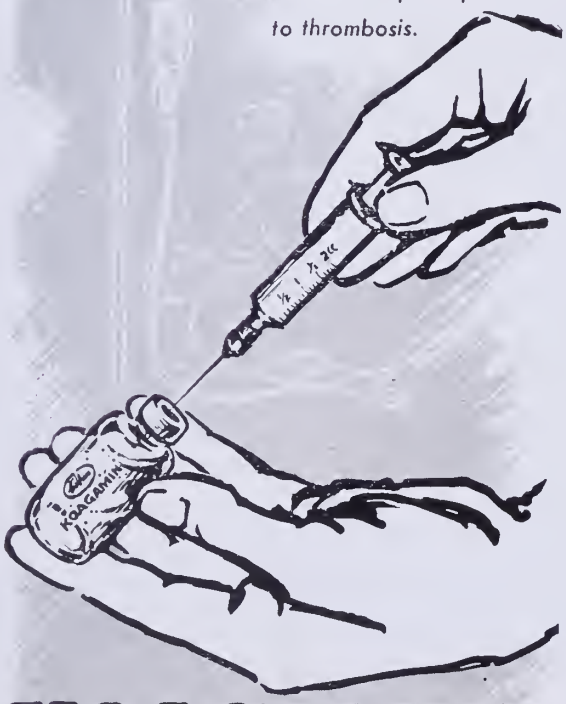

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hemodialysis and medical statistics and find information of value.

The book is recommended to any anesthesiologist, trainee or candidate seeking review material.—Harry S. Weeks, M. D.

* * * *

HANDBOOK OF LEGAL MEDICINE—By Alan R. Moritz, M. D., Professor of Pathology and Director of the Institute of Pathology, Western Reserve University, Cleveland, Ohio, and C. Joseph Stetler, LL. B., LL. M., Executive Vice-President and General Counsel, Pharmaceutical Manufacturers Association, Washington, D. C. Pgs. 239. The C. V. Mosby Company, St. Louis, 1964. Price $5.75.

This little book in the second edition makes interesting reading in these days of million dollar medical liability insurance.

The authors are competent in their respective fields and have combined to write a book of interest and value to most of our colleagues, regardless of their field or specialty of medicine.

As stated in the preface—it is designed and written for daily use and is clearly intended for ready reference rather than detailed research.

In Part I, entitled "Scientific Medico-Legal Investigation," there are 14 chapters ranging from physicians' responsibilities, determination of time of death, rape, abortion, poisoning, etc.

The second part, entitled "Physicians and Patient—Physician and the Law," has 40 short chapters including one entitled Medical Societies, which might be read with deep interest by members of some county societies.

In this day of *res ipsa loquitur* and predatory claimants this little volume will give much needed information to many practitioners. If the million dollar liability policy is a "must" so is the "Handbook of Legal Medicine."

* * * *

CURRENT DIAGNOSIS & TREATMENT—By Henry Brainerd, M. D., Sheldon Margen, M. D., Milton J. Chatton, M. D., and Associate Authors. Pp. 870. 1964. Lange Medical Publications, P. O. Box 1215, Los Altos, California. Price $9.50.

Current Diagnosis and Treatment, First Edition, by three West Coast medical professors, is a helpful and readable volume of immediate interest to the busy medical practitioner.

The Book has 48 Chapters and covers all fields of medicine. It has a normal value section and an appendix covering "unestablished drugs" which is a forthright presentation of enzymes, vitamins, vasodilators, etc., of no demonstrated value.

Each disease is presented under the headings, essentials of diagnosis, general considerations, clinical findings, prevention, treatment and prognosis and is followed by a few outstanding references.

All descriptions are brief and terse but quite informing. The print is small but legible, headings are prominent and the index is conclusive.

The book will be appreciated by many busy office practitioners.

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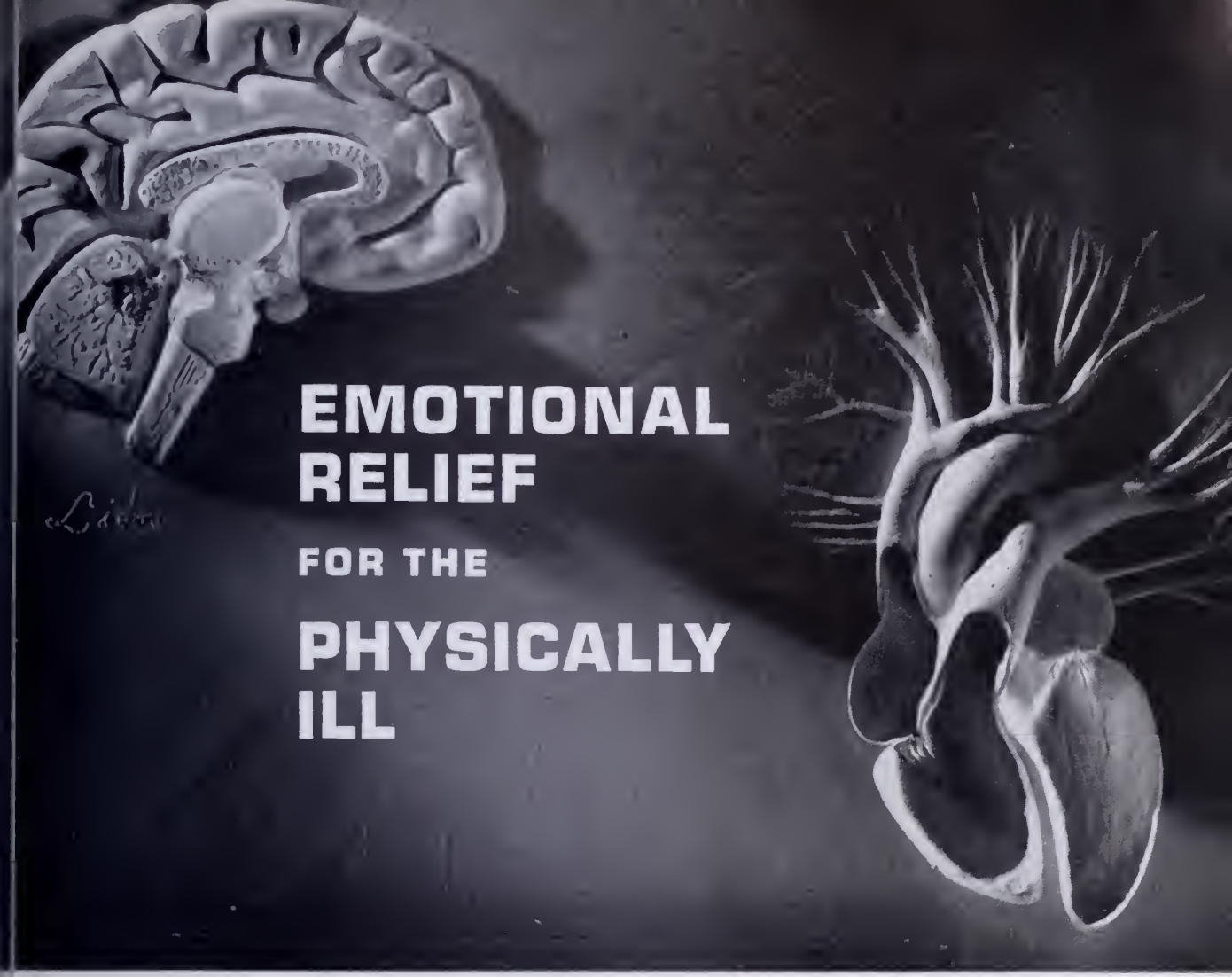

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The report, based on statistics through December 31, 1962, showed that West Virginia compared favorably with the national figure of 76 per cent of the civilian population having health insurance.

The 1.3 million West Virginians who had hospital expense insurance and 1.26 million with surgical expense insurance received $60.6 million in benefits in 1961. The average hospital stay was seven days and the cost $208.

Make Your Reservation Now!

Members of the West Virginia State Medical Association are urged to make reservations without delay for accommodations during the 97th Annual Meeting at The Greenbrier in White Sulphur Springs, August 20-22, 1964. Application forms for room reservations were enclosed in a bulletin mailed recently to each member. The completed forms should be mailed directly to the Reservation Manager, The Greenbrier, White Sulphur Springs, West Virginia.

Heart Association Awards Available For Medical Education Research

Heart Association awards for research in medical education are now available on a short term basis to West Virginia physicians who wish to analyze specific problems in this area but cannot devote full time to the work.

The new awards were inaugurated by the Association's Committee on Professional Education and are designed especially for physicians who wish to devote perhaps two months annually to techniques for analyzing specific problems which may arise at their institutions.

Two short-term grants, each carrying a $2,500 stipend, will be awarded yearly. Futher information may be obtained by writing to the West Virginia Heart Association, 759 West Washington Street, Charleston, West Virginia 25302.

Books Received

CANCER OF THE STOMACH—By William H. ReMine, M. D., M. S. in Surgery, F. A. C. S.; and James T. Priestley, M. D., M. S. in Experimental Surgery, F. A. C. S.; Joseph Berkson, M. D., D. Sc. and Members of the Staff of the Mayo Clinic. Pp. 255, Illustrated; W. B. Saunders Company, Philadelphia. 1964. Price $11.50.

* * * *

MEDICAL PHARMACOLOGY.—By Andres Goth, M. D., Professor of Pharmacology and Chairman of the Department, The University of Texas Southwestern Medical School, Dallas, Texas. Pp. 585. The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Missouri. 1964. Price $11.75.

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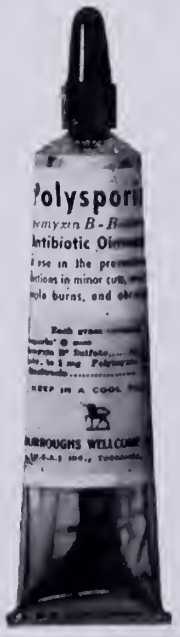

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JUNE
1964

Vol. 60 No. 6

The WEST VIRGINIA Medical Journal

Official Organ of the West Virginia State Medical Association

Box 1031 Charleston, W. Va. 25324

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CONTENTS

Scientific Articles

Survey of Snakebites in West Virginia—Henry M. Parrish, M. D., Dr. P. H. 143
Hyperuricemia, Gout and Cerebrovascular Disease—John S. Meyer, M. D., George P. Kypros, M. D., and John Gilroy, M. D. 150
Massive Blood Replacement—Norman W. B. Craythorne, M. D. 154

Special Article

Mental Health Planning in West Virginia—Mrs. John W. Hash 157

The President's Page

Progress, Excellence and Freedom — Charles L. Goodhand, President, West Virginia State Medical Association 160

Editorials

Some Problems in Medical Licensing in West Virginia 161
Harrison County Scholarship Program 163

General News

Plans Near Completion for Annual Meeting 164
Public Health Association Meeting 165
Dr. O. W. Ladwig 'GP of the Year' 165
New Oph. & Otol. Officers 166
Dr. Hu C. Myers ACS President 167
AMA Meeting in San Francisco 168
Mrs. Thomas L. Harris Honored 168
Duties of County Coroners 170
Auxiliary Board Meeting 171
Spring Meeting of Council 172

Special Departments

WVU Medical Center News xx
The Month in Washington xxii
Annual Audit xxiv
Obituaries xxx
County Societies xxxi
The Woman's Auxiliary xxxiv
Directory of Physicians in Limited Practice xli
Book Reviews xxxviii
Index to Advertisers xliv

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J. Englebert Dunphy, Consulting Editor

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In this new monograph, Dr. Child and 12 collaborators present a complete picture of the nature of portal hypertension and its surgical management. You will find discussions of such vital surgical considerations as: *the effectiveness of portacaval and splenorenal shunts; selection of patients for operation; arguments for and against "prophylactic" shunt procedures in the patient with esophageal varices; relative advantages of end-to-side and side-to-side shunting.* Management of the patient with active bleeding esophageal varices is helpfully discussed. In addition, Dr. Child and his eminent collaborators evaluate current concepts of pathologic physiology of portal hypertension; they detail the essentials of medical and supportive management.

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Research in the Service of Medicine

WVU Medical Center
—News—

Ten members of the West Virginia University School of Medicine faculty have received promotions. Four are in fields of the basic sciences, five in surgery and one in pediatrics.

Elevated from assistant professor to associate professor were Drs. Samuel J. Deal, microbiology; William W. Fleming, pharmacology; John E. Hall, microbiology; Russell V. Lucas, Jr., pediatrics; and George R. Nugent, neurosurgery.

Promoted from clinical assistant to clinical associates of surgery were Drs. Edgar F. Heiskell, Jr., Lawrance S. Miller and Maynard P. Pride, all of Morgantown.

Dr. Shaotsu Lee and Mr. Dane W. Moore, Jr., were promoted from instructor to assistant professor in surgery and pathology.

Lectures by Minnesota Physician

Dr. Cecil J. Watson, Professor and Head of the Department of Medicine at the University of Minnesota Medical School, presented two lectures at the WVU Medical Center, May 7-8.

Doctor Watson presented papers on "Recent Studies of Porphyria," and "Hemoglobin and Bile Pigment Metabolism" as part of the continuing educational program for faculty, students and staff.

He is an outstanding student and an authority on the subjects of hemoglobin, bile pigment and porphyrin metabolism. His original work in this field was done in the laboratory of Dr. Hans Fischer, the German biological chemist who elucidated the structural formulae of porphyrins and related compounds.

Hospital Hosts Appalachian Administrators

The WVU Hospital was host to the second meeting of the Appalachian Council of University Hospitals, May 1-2. Hospital directors from six states and the District of Columbia compose the council.

The organization was formed in 1963 for the purpose of discussing problems of mutual interest in university hospitals in the Appalachian region of the United States.

In addition to West Virginia and the District of Columbia, other states represented in the council are Virginia, Kentucky, Tennessee, North Carolina and Maryland.

Three Papers Presented in Chicago

Three members of the WVU School of Medicine faculty and three students prepared papers for presentation before the Federation of American Societies for Experimental Biology meeting in Chicago, April 12-17.

• **Compiled from material furnished by Howard Lewis, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

Dr. Rex B. Conn, Jr., Associate Professor of Pathology and Director of the WVU Hospital's clinical laboratories, presented a paper on "Excretion of Hippuran I^{131} Following Single Intravenous Injection in the Dog." The paper was prepared in conjunction with Alex Sabo of Morgantown and Dale Landes of Riverton, third-year students.

Dr. Robert J. Marshall, Professor of Medicine, delivered a paper on "Effects of Graded Exercise on Cardiac Performance in Normal Man and in Dogs."

Dr. A. C. Edmundowicz, Assistant Professor of Medicine, presented a paper on "Cardiac Output During Cigarette Smoking." Co-authors were R. L. Pifer, second-year student from Keyser, and Doctor Marshall.

Doctor Zimmermann Lectures at Virginia

Dr. Bernard Zimmermann, Professor and Chairman of Surgery at the WVU School of Medicine, presented the annual Alpha Omega Alpha lecture at the University of Virginia School of Medicine in Charlottesville on April 30.

Doctor Zimmermann's topic was "From Sea to Surgery," a discussion of the development of the body's mechanisms from the time life emerged from the sea until the present.

Named to NIH Grants Committee

Dr. Daniel T. Watts, Professor and Chairman of Pharmacology at the WVU School of Medicine, has been appointed to the Pharmacology Training Grants Committee of the National Institutes of Health.

The four-year appointment runs from June 1, 1964 through June 30, 1968. During this time, Doctor Watts will help decide the merit of grant requests from medical schools and other facilities as they relate to pharmacology education. In addition, he will help advise NIH on areas in which research training activities should be initiated or expanded.

AHA Honors Hospital Director

Mr. E. L. Staples, Director of the WVU Hospital, has been elected to the seven-member Committee on Rehabilitation of the American Hospital Association.

The AHA has charged this committee with the development of a manual on restorative services and recommended programs of hospitals, clinics, nursing homes and other health care facilities.

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE American Medical Association and the American Pharmaceutical Association have warned Congress that too stringent regulations for clinical testing could result in valuable new drugs not being approved.

The two associations testified before a House Government Operations subcommittee, headed by Rep. L. H. Fountain (D., N. C.) during its study of drug safety requirements from both government and industry aspects.

In another development, a federal district court held that regulations of the U. S. Food and Drug Act requiring repetition of the generic names of prescription drugs in labeling and advertising each time brand names are mentioned are not valid.

After a Silver Spring, Maryland, physician pleaded "no contest" to five counts of an indictment, the FDA said it would recommend that the Department of Justice take vigorous action against anyone suspected of falsifying drug research records. The Silver Spring physician had been indicted on charges of submitting false reports of clinical studies of five new drugs.

"While scientists in general have the highest integrity and the falsification of research data is the rare exception, this Agency views such falsification when it does occur as a menace to the public health," FDA Commissioner George P. Larrick said.

The American Medical Association testified that "even the most extensive pre-marketing clinical tests cannot always be relied upon as completely predictive of human toxicity." Dr. Hugh H. Hussey, director of the AMA's Division of Scientific Activities, told the subcommittee that "it is entirely possible that more lives could be lost by keeping a valuable drug off the market during extensive clinical trials than would be saved by gaining a precise knowledge of the exact type and incidence of all side effects."

Always an Element of Risk

"Physicians realize that no drug can be considered completely safe. There is always an element of risk, no matter how small, whenever a chemical agent is administered to a patient. That risk can be minimized by adequate animal testing and pre-marketing clinical trials; it can never be eliminated."

Cautioning against government regulations that become unnecessarily burdensome and restrictive, Doctor Hussey said the vital knowledge about drug toxicity "can be obtained only by utilizing the combined experience of the ultimate evaluators of drug safety—the well informed practicing physicians of the United States."

He pointed out that it is now known that the antibiotic chloramphenicol (Chloromycetin) can produce aplastic anemia. "The incidence of this adverse reaction has been estimated from as much as one in 60,000 to as little as one in 225,000," he noted.

"Using the high incidence figure, it can be seen that, statistically, it would be possible to treat 60,000 patients with the drug before a single case of aplastic anemia occurred," Doctor Hussey testified. "It is impractical and unreasonable to conduct clinical tests of this magnitude. Like animal tests, then, pre-marketing clinical trials are subject to certain limitations and can never supplant widespread clinical use as a means of assessing the ultimate hazards of a drug."

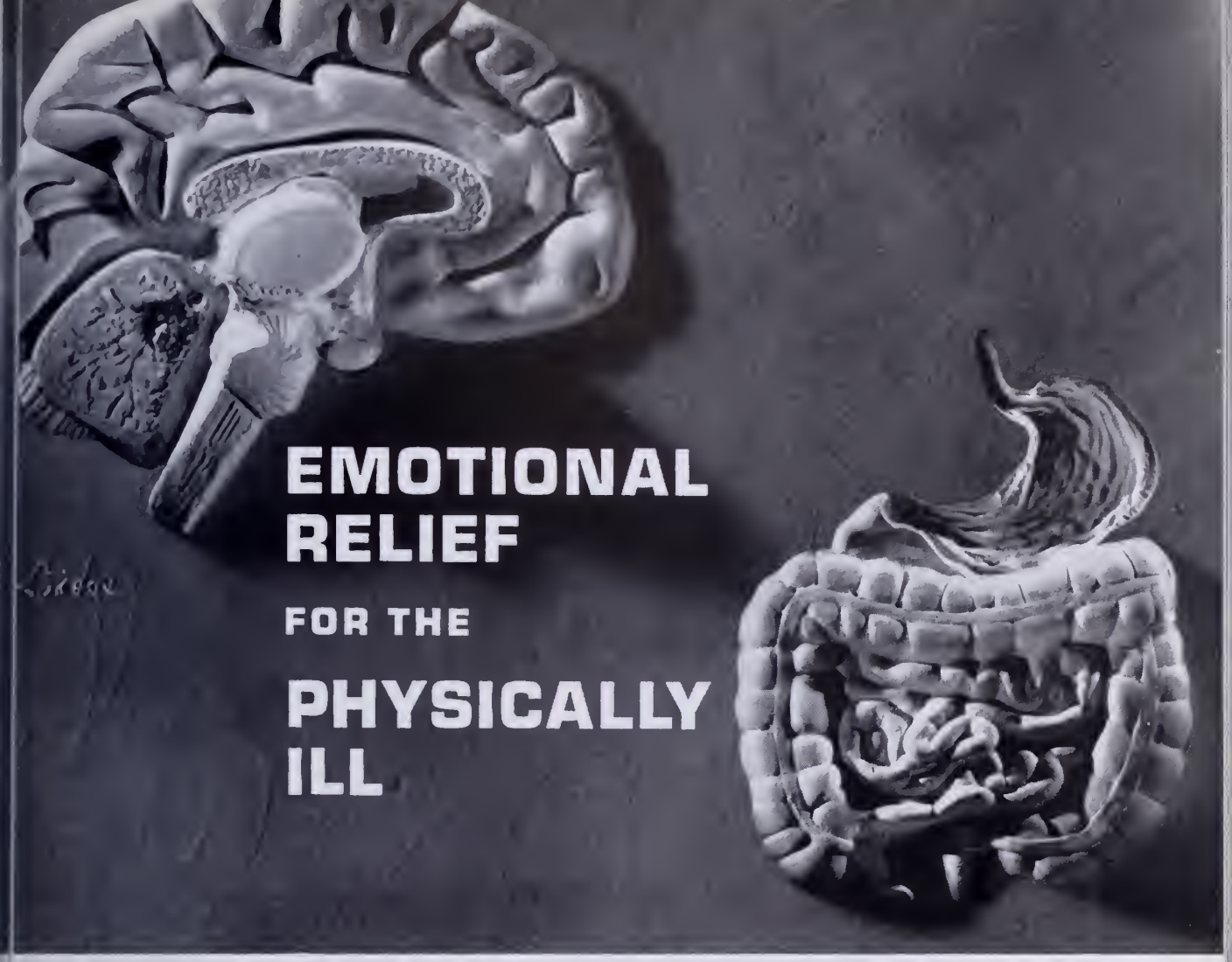
The American Pharmaceutical Association said that it was "concerned that the hysteria of the moment about drug safety could develop into an unwritten protocol of indecision and delay." William S. Apple, executive director of the APA, said "the general public and individual patients must be informed that a benefit-to-risk ratio will always exist, and that every effort is being made to reduce the risk and increase the benefit."

Expansion of VA Program Opposed

The American Medical Association has reiterated its opposition to military veterans getting free hospital services for non-service-connected disabilities and illnesses.

Dr. Russell B. Roth of Erie, Pennsylvania, a consultant at the Erie Veterans Administration Hospital, and Dr. David B. Allman of Atlantic City, New Jersey, a past president of the AMA, spoke for the AMA at a hearing of the House Veterans Subcommittee that was considering legislation that would expand the free government hospital services available to veterans with non-service-connected medical conditions.

Roth singled out for special criticism two bills that would expand outpatient services. "At the lowest estimate," he said, "these two bills would make some four million men eligible for complete outpatient care, dental as well as medical; either bill alone would make over two million men eligible, without regard to either a medical determination of service connection or the veteran's ability to meet the cost of such care.



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Annual Audit, 1963

The annual audit of receipts and disbursements of the West Virginia State Medical Association for the calendar year 1963 has been completed by the firm of Fitzhugh, Erwin, McKee and Hickman, Certified Public Accountants of Charleston. The complete audit, with letter of transmittal, follows:

FITZHUGH, ERWIN, McKEE & HICKMAN
Certified Public Accountants
Kanawha Banking & Trust Building
Charleston 1, W. Va.

West Virginia State Medical Association
Charleston, West Virginia

We have examined the summary statement of cash receipts and disbursements of the West Virginia State Medical Association and the statements of cash receipts and disbursements by funds, for the year ended December 31, 1963, and the statement of securities owned at December 31, 1963. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying summary statement of cash receipts and disbursements and the statements of cash receipts and disbursements by funds present fairly the recorded cash transactions of the West Virginia State Medical Association for the year ended December 31, 1963, and securities owned by the Association at December 31, 1963.

FITZHUGH, ERWIN, McKEE & HICKMAN

Charleston, W. Va.
April 30, 1964

SUMMARY STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS CALENDAR YEAR 1963

CASH IN BANK—JANUARY 1, 1963		$ 32,190.34
RECEIPTS		
Dues—see footnote	$ 56,366.00	
Interest on U. S. Bonds	800.00	
Collection Commission on A.M.A. Dues	567.49	
Advertising	23,978.61	
Emblems sold	61.75	
Subscriptions	728.00	
Exhibit space sold	6,160.00	
Dues collected for A.M.A.	62,955.00	
Interest on savings	247.25	
Contributions to Medical Scholarship Fund	7,054.00	
Refunds	898.45	
Employee contributions—Employee Benefit Plan	405.57	
Total Receipts		160,222.12
		192,412.46
DISBURSEMENTS		
General Fund	52,918.16	
Medical Journal Fund	31,820.38	
Convention Fund	8,804.39	
Dues forwarded to A.M.A.	62,955.00	
Medical Scholarship Fund	5,342.86	
Public Service Fund	659.66	
Total Disbursements		162,500.45
CASH IN BANK—DECEMBER 31, 1963		$ 29,912.01

	1-1-1963	12-31-1963
Cash in bank—Savings Account	6,120.00	6,367.25
Cash in bank—Checking Account	26,070.34	23,544.76
Total	$ 32,190.34	$ 29,912.01

Membership dues as reflected above includes 1964 dues of $7,650.00 collected in December, 1963.

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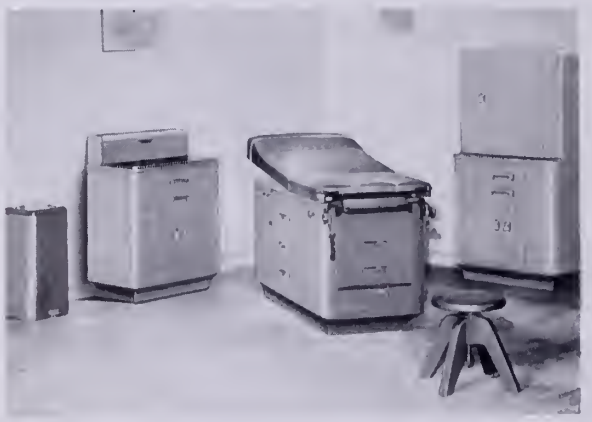

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GENERAL FUND

Statement of Cash Receipts and Disbursements Calendar Year 1963

BALANCE—JANUARY 1, 1963		$ 11,984.02
RECEIPTS		
Dues (allocated to General Fund)—see footnote	$ 43,451.00	
Interest on U. S. Bonds	650.00	
Collection Commission on A.M.A. Dues	567.49	
Refunds	122.10	
Employee contribution—Employee Benefit Plan	405.57	
Total Receipts		45,196.16
		57,180.18
DISBURSEMENTS		
Salaries—Executive Secretary	9,249.99	
—Office	14,739.23	
Office supplies and expense	2,995.46	
Office rent	3,180.00	
Library expense	255.80	
Telephone and telegraph	2,523.36	
Postage	1,764.79	
Travel	3,426.17	
Legal and auditing	1,677.16	
Legislative bulletins and expense	1,444.20	
Payroll taxes	1,135.30	
Unemployment tax	558.75	
Mimeographing	1,126.15	
Expense of Council and Committee meetings	5,316.30	
Miscellaneous expense	1,544.08	
Employee Benefit Plan	1,460.79	
Office equipment and furnishings	520.63	
Total Disbursements		52,918.16
BALANCE—DECEMBER 31, 1963		$ 4,262.02

Membership dues allocated to the General Fund as reflected above includes 1964 dues of $6,273.00 collected in December, 1963.

MEDICAL JOURNAL FUND

Statement of Cash Receipts and Disbursements Calendar Year 1963

BALANCE—JANUARY 1, 1963		$ 3,597.38
RECEIPTS		
Advertising	$ 23,978.61	
Emblems sold	61.75	
Subscriptions	728.00	
Refunds and discounts	651.35	
Total Receipts		25,419.71
		29,017.09
DISBURSEMENTS		
Printing	22,971.81	
Engraving	928.09	
Postage	791.00	
Salaries and editing	6,164.99	
Miscellaneous	964.49	
Total Disbursements		31,820.38
BALANCE—DECEMBER 31, 1963 (deficit)		($ 2,803.29)

CONVENTION FUND

Statement of Cash Receipts and Disbursements Calendar Year 1963

BALANCE—JANUARY 1, 1963		$ 1,679.73
RECEIPTS		
Exhibit space sold	$ 6,160.00	
Dues (allocated to Convention Fund)—see footnote	4,305.00	
Refunds:		
Convention Golf Tournament	125.00	
Total Receipts		10,590.00
		12,269.73

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DISBURSEMENTS		
Supplies and labor	4,535.68	
Travel	642.74	
Entertainment	2,167.90	
Telephone and telegraph	314.22	
Advance Convention Golf Tournament	250.00	
Reporting	255.85	
Miscellaneous	388.00	
Auxiliary Convention expense	250.00	
Total Disbursements		8,804.39
BALANCE—DECEMBER 31, 1963		$ 3,465.34

Membership dues allocated to the Convention Fund as reflected above includes 1964 dues of $459.00 collected in December, 1963.

AMERICAN MEDICAL ASSOCIATION DUES

Statement of Cash Receipts and Disbursements Calendar Year 1963

BALANCE—JANUARY 1, 1963	$ None
RECEIPTS	
Dues collected for A.M.A.	62,955.00
	62,955.00
DISBURSEMENTS	
Dues forwarded to A.M.A.	62,955.00
BALANCE DUE A.M.A.—DECEMBER 31, 1963	$ None

PUBLIC SERVICE FUND

Statement of Cash Receipts and Disbursements Calendar Year 1963

BALANCE STATE ASSESSMENTS— JANUARY 1, 1963	$ 598.06
RECEIPTS	
Assessments	None
	598.06
DISBURSEMENTS	
Conference and general expense	659.66
BALANCE STATE ASSESSMENTS— DECEMBER 31, 1963 (deficit)	($ 61.60)

MEDICAL SCHOLARSHIP FUND

Statement of Cash Receipts and Disbursements Calendar Year 1963

BALANCE—JANUARY 1, 1963		$ 14,331.15
RECEIPTS		
Dues (allocated to Medical Scholarship Fund)—see footnote	$ 8,610.00	
Contributions	7,054.00	
Interest on U. S. Treasury Bonds	150.00	
Interest on Savings Account	247.25	
Total Receipts		16,061.25
		30,392.40
DISBURSEMENTS		
Scholarship installment	5,000.00	
Travel, printing and miscellaneous expense	342.86	
Total Disbursements		5,342.86
BALANCE—DECEMBER 31, 1963		$ 25,049.54
Balance in Savings Account	6,367.25	
Balance in General Fund Checking Account	18,682.29	
Total	$ 25,049.54	

Membership dues allocated to the Medical Scholarship Fund as reflected above includes 1964 dues of $918.00 collected in December, 1963.

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SCHEDULE OF BONDS OWNED AS OF DECEMBER 31, 1963

	Serial	Due Date	Maturity Value
U. S. Treasury 2½%	27070L	12-15-67/72	$10,000.00
U. S. Treasury 2½%	27846F	12-15-67/72	10,000.00
U. S. Treasury 2½%	70011A	12-15-67/72	1,000.00
U. S. Treasury 2½%	70012B	12-15-67/72	1,000.00
U. S. Treasury 2½% (Medical Scholarship Fund)	72361A	12-15-67/72	1,000.00
U. S. Treasury 2½%	19534D	12-15-67/72	500.00
U. S. Treasury 2½%	20707H	12-15-67/72	500.00
U. S. Treasury 2½%	20935E	12-15-67/72	500.00
U. S. Treasury 2½%	21421A	12-15-67/72	500.00
U. S. Treasury 2½%	21914D	12-15-67/72	500.00
U. S. Treasury 2½%	22646F	12-15-67/72	500.00
U. S. Treasury 2½% (Medical Scholarship Fund)	6873C	9-15-67/72	5,000.00
U. S. Treasury 2½% (Medical Scholarship Fund)	18939K	9-15-67/72	1,000.00
Series "J"	Q22297J	1- 1-1968	25.00
Series "J"	Q22298J	1- 1-1968	25.00
Total			$ 32,050.00

COMPARATIVE SCHEDULE OF CASH AND BONDS AS OF DECEMBER 31, 1962 AND 1963

	12-31-62	12-31-63	Increase (Decrease)
CASH			
General Fund	$11,984.02	$ 4,262.02	($ 7,722.00)
Medical Journal Fund	3,597.38	(2,803.29)	(6,400.67)
Convention Fund	1,679.73	3,465.34	1,785.61
A.M.A. Dues			
Public Service Fund	598.06	(61.60)	(659.66)
Medical Scholarship Fund	14,331.15	25,049.54	10,718.39
Total Cash	32,190.34	29,912.01	(2,278.33)
U. S. BONDS (at cost)	31,144.91	31,144.91	
TOTAL CASH & BONDS	$63,335.25	$61,056.92	($ 2,278.33)

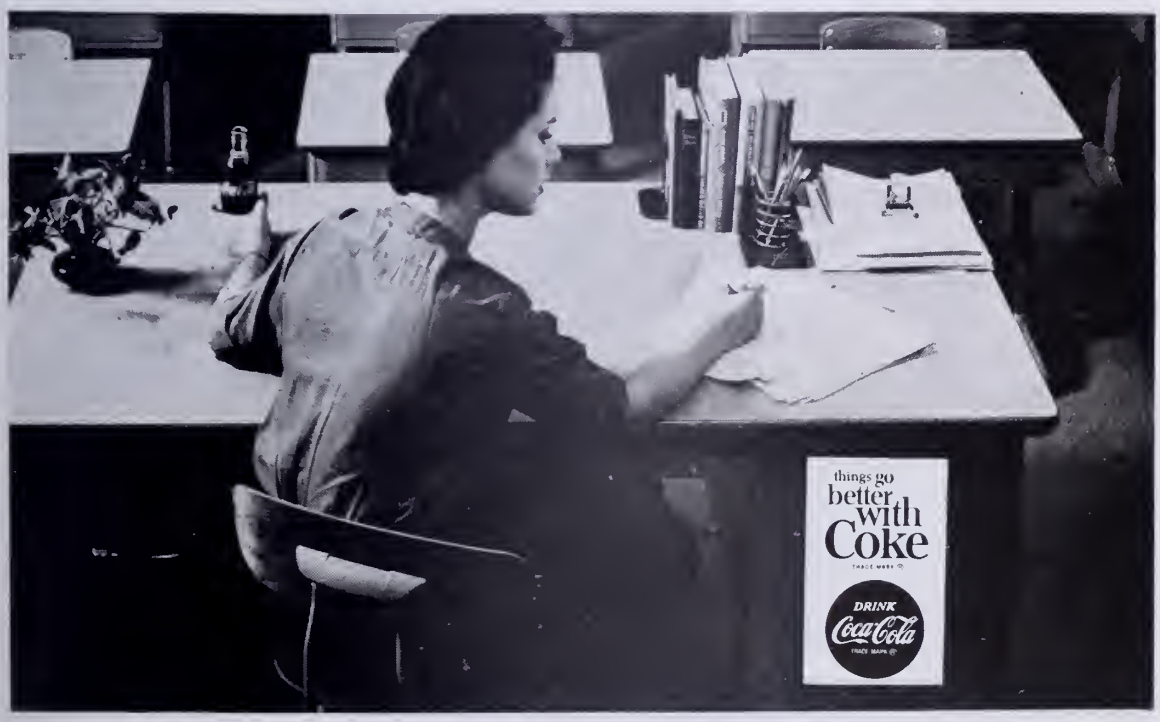
RESIDENCIES AVAILABLE

GENERAL PRACTICE RESIDENCY—JCAH approved hospital active teaching program. Location excellent for future practice. Must have ECFMG and immigrant status. Excellent stipend. Write Administrator, Thomas Memorial Hospital, South Charleston, W. Va.

PSYCHIATRIC RESIDENCIES FOR GP'S—NIMH residency training in approved three-year program. Stipend $11,500 to $12,000. Applicants must have completed four years or more of practice in field of medicine other than psychiatry after an approved internship. Applicants should not be over 40. Write to Chairman, Department of Psychiatry, Medical College of Virginia, Richmond, Virginia. Include curriculum vitae.

INTERNAL MEDICINE RESIDENCIES—Three-year approval in a 280-bed general hospital; isotope laboratory; cobalt therapy; open and closed heart surgery. Attendings are board certified or board eligible practicing internists. Full-time Director of Medical Education and active teaching program. Brochure available upon request. Apply to Dr. C. D. Gettliffe, Director of Medical Education, Charleston General Hospital, Charleston 25, W. Va.

PATHOLOGY RESIDENCY—Four-year fully approved A.P. and C.P. 280-bed general hospital; 6,000 surgicals; 23,000 clinical; 6,000 cytological; 140 autopsies (15 per cent medico-legal); Two Board Pathologists, A.P., C.P., F.P. University affiliation. Salary, $275 to $350 per month, $75 family allowance; Blue Cross. Contact Dr. Peter Ladewig, Charleston General Hospital, Charleston, W. Va.



Whether you're a teacher correcting exams. A student cramming for them. A housewife cleaning up after the kids. Or a businessman working late at night. Whoever you are, things go better when you pause and refresh with ice-cold Coca-Cola.

RECOGNIZE THIS PATIENT?

"I can't cope any more . . . the kids drive me crazy. I worry about everything . . . feel exhausted all the time."

When you recognize depression and anxiety traceable to an emotionally charged situation with no somatic disorder

—*start the patient on 'Deprol'*

Typical situations in which 'Deprol' is indicated:

marital or other family problems ■ death of a loved one ■ financial worries ■ fear of cancer, heart disease or other life-threatening illness ■ pre- and post-operative apprehensions ■ retirement problems, and many other stressful situations which cause the patient to feel a sense of loss, guilt or unworthiness

Advantages of 'Deprol'

1. By relieving both depression and anxiety, 'Deprol' lifts the mood of the depressed patient without the agitation and "jitters" that often accompany "energizer" therapy alone.
2. 'Deprol' restores normal sleep, relaxes physical tensions, and improves appetite.
3. 'Deprol' acts rapidly—patients often respond within a week or two.
4. 'Deprol' is relatively nontoxic and free of side effects.
5. When depression and anxiety accompany physical illness, 'Deprol' is compatible with drugs used to treat these organic conditions.

Deprol®

meprobamate 400 mg. + benactyzine hydrochloride 1 mg.

Side effects: Slight drowsiness and, rarely, allergic or idiosyncratic reactions, due to meprobamate, and occasional dizziness or feeling of depersonalization in higher dosage, due to benactyzine, may occur. **Contraindications:** Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use of meprobamate or meprobamate-containing drugs. **Precautions:** Should administration of meprobamate cause drowsiness, the dose should be reduced. Operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Although suicides with 'Deprol' have not been reported, prescribe cautiously and in small quantities to patients with suicidal tendencies. Massive overdosage of meprobamate may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse. Even though it has not been reported with 'Deprol', consider the possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after prolonged use at high dosage. *Complete product information available in the product package, and to physicians on request.*

Usual adult dosage: 1 tablet t.i.d. or q.i.d. May be increased gradually, as needed, to 6 tablets daily. With establishment of relief, may be gradually reduced to maintenance levels. **Supplied:** Light-pink, scored tablets Bottles of 50.

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HUNTINGTON, WEST VIRGINIA

Obituaries

ROBERT THORNHILL COFFMAN, M. D.

Dr. Robert Thornhill Coffman, 49, former Chief of Surgery and President of Potomac Hospital Corporation in Keyser, died on April 23 at a Cincinnati hospital.

Doctor Coffman, who was serving on the staff of St. Francis Hospital in Cincinnati at the time of his death, was a native of Belington. He was born on March 29, 1915, the son of Walter E. and Mary L. Coffman.

He attended public schools in Keyser and was graduated from Potomac State College in 1935. He received his M. D. degree in 1939 from the University of Maryland School of Medicine.

He served an internship and residency in surgery at the Maryland General Hospital in Baltimore, 1939-43. During World War II he served 38 months in the Medical Corps of the United States Army and was released with the rank of Major.

Doctor Coffman was a former member of the Potomac Valley Medical Society and the West Virginia State Medical Association.

Besides his widow, he is survived by two daughters, Mrs. Nancy Lee Howard of Morgantown and Miss Barbara Ann Coffman of Keyser; a brother, William Coffman of Princeton, New Jersey, and a sister, Mrs. Mary Frances Perdew of Agana, Guam.

* * * *

WILMER G. OLIPHANT, M. D.

Dr. Wilmer G. Oliphant, 49, of Terre Haute, Indiana, died on February 10 at a hospital in that city.

Doctor Oliphant, formerly of Burnwell, Kanawha County, and Morgantown, was born at Tamroy, West Virginia, on January 4, 1915. He attended the two-year School of Medicine at West Virginia University and received his M. D. degree in 1951 from the Medical College of Virginia.

He served an internship at Charleston General Hospital, 1951-52, and a residency in anesthesiology at the University of Tennessee Research Center and Hospital in Knoxville, Tennessee, 1958-59, and the Medical College of South Carolina in Charleston, South Carolina, 1959-60.

He was a member of the staff at two Morgantown hospitals, 1960-61, before relocating in Terre Haute, where he served as a member of the staff of St. Anthony Hospital until his death.

Doctor Oliphant was a former member of the Kanawha Medical Society and the West Virginia State Medical Association.

Besides his widow, Mrs. Bonnie C. Oliphant, he is survived by two step-daughters, Mrs. Mary Jane Bailey of Knoxville, Tennessee, and Miss Sue Morgan of Terre Haute; a brother, Dr. W. W. Oliphant of Lake Orion, Michigan; and six brothers and a sister, all of California.

County Societies

BARBOUR-RANDOLPH-TUCKER

The Rev. Ward W. Hibbs of Alderson-Broaddus College was the guest speaker at the regular meeting of the Barbour-Randolph-Tucker County Medical Society which was held at the Philippi Inn on April 16.

Doctor Hibbs, who conducted the in-service training program for ministers at Alderson-Broaddus, established the following rules of conduct for the clergy in relation to patients:

1. Avoid use of medical terms.
2. Win approval by deeds.
3. Work in close harmony with physicians.
4. Never volunteer medical advice but strengthen the patient's faith in his physician.
5. The minister is to leave when the physician appears.
6. Work with the family and add influence to that of the physician for the purpose of obtaining autopsy, etc.

During the business meeting it was announced that the Annual Postgraduate Meeting of the Society would be held at the Elks Country Club near Elkins on June 18. Dr. Charles L. Leonard of Elkins will serve

Radiology:
KARL J. MYERS, M. D.

Pathology:
S. D. WU, M. D.

Surgery:
HU C. MYERS, M. D.
A. KYLE BUSH, M. D.

Gynecology and Obstetrics:
RAYMOND W. CRONLUND, M. D.

Internal Medicine:
JOHN E. LENOX, M. D.
J. L. RITTMEYER, M. D.
ERNEST G. GUY, M. D.

Pediatrics:
CORA C. LENOX, M. D.

Dentistry:
GLENN B. POLING, D. D. S.

Anesthesiology:
G. E. HARTLE, M. D.

Brooddus Hospital Resident Staff:
RUSSELL C. HERMAN, M. D.
JOSIAH THOMPSON, M. D.
LUIS GUTIERREZ, M. D.

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Philippi, West Virginia

reduce or obviate the need for transfusions and their attendant dangers

KOAGAMIN is indicated whenever capillary or venous bleeding presents a problem. KOAGAMIN has an outstanding safety record -- in 25 years of use no report of an untaward reaction has been received; however, it should be used with care on patients with a predisposition to thrombosis.

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parenteral hemostat

Each cc contains: 5 mg. axalic acid, 2.5 mg. malanic acid, phenal 0.25%; sadium carbonate as buffer.

Complete data with each 10cc vial. Therapy chart an request.

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as moderator for a "Symposium on Alcoholism."—A. Kyle Bush, M. D., Secretary.

* * * *

MARION

Dr. H. Curtis Wood, Jr., of Fort Washington, Pennsylvania, was the guest speaker at the annual joint meeting of the Marion County Medical Society and the Marion County Bar Association which was held at the Fairmont Hotel in Fairmont on March 31.

Doctor Wood, a past president of the Pennsylvania League for Planned Parenthood, discussed "Voluntary Sterilization—The Facts and the Myths."

* * * *

MERCER

The regular monthly meeting of the Mercer County Medical Society was held at the West Virginian Hotel in Bluefield on March 16.

The guest speakers were Mr. Jerome Katz and Mr. Norris Kantor, who discussed wills and estate planning.

During the business meeting, the Society voted unanimously to accept Dr. John J. Bryan's outline of the Mercer County participation in the program, "Home Town USA."—J. Brookins Taylor, M. D. Secretary.

* * * *

MONONGALIA

Dr. Charles L. Goodhand of Parkersburg was the guest speaker at the regular monthly meeting of the Monongalia County Medical Society which was held in Morgantown on April 7.

Doctor Goodhand, President of the West Virginia State Medical Association, discussed "Medical Progress and Its Responsibility."

Dr. R. F. Krause, the president, presided at the business meeting which was attended by 34 members. —William E. King, M. D., Secretary.

* * * *

PARKERSBURG ACADEMY

The Parkersburg Academy of Medicine held its regular monthly meeting at the American Legion home in Parkersburg on April 2.

Dr. Bertha A. Bouroncle, Associate Professor of Medicine at the Ohio State University College of Medicine, was the guest speaker. She presented a paper on leukemia and its treatment.

Dr. Robert C. Lincicome, the president, presided at the business meeting.

* * * *

PRESTON

Dr. Ralph W. Ryan of Morgantown was the guest speaker at the annual joint meeting of the Preston County Medical Society and the Preston County Bar Asociation which was held at the Preston County Country Club near Kingwood on April 4.

Doctor Ryan presented a paper on "The Eye Banks in Corneal Transplant Surgery."

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Appearances on the outside do not necessarily suggest what goes on inside. This is particularly true of the ulcer patient, who may appear jolly and unruffled to his neighbors, but presents to you the classic symptoms: organic and functional disorders of the G.I. tract, associated with anxiety and tension.

Consider, when you see him next, the value of PATHILON® SEQUELS® with Phenobarbital, which provides sustained anticholinergic protection from spasm and pain in the target areas, as well as sustained phenobarbital action against triggering anxiety. The controlled release of the active ingredients in the SEQUELS® formulation means protective medication day and night.

Effective in peptic ulcer, intestinal colic, ileitis, esophageal spasm, spastic colon, alcohol-induced G.I. upsets, gastric hypermotility and anxiety neurosis with G.I. symptoms. Should be used as adjunct to other measures.

Side Effects (due to tridihexethyl chloride): dry mouth, blurring of vision, constipation.

Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention.

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Each capsule contains: Tridihexethyl chloride, 75 mg., and phenobarbital, 45 mg.

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RALEIGH

Dr. Albert D. Kistin was the speaker at the regular monthly meeting of the Raleigh County Medical Society which was held at the El Chico Restaurant in Beckley on March 19.

Doctor Kistin, Chief of Medicine at Beckley Memorial Hospital, discussed "New Developments in the Management of Cardiac Arrhythmia and New Problems."

Dr. Harold I. Amory of Morgantown was the guest speaker at the regular monthly meeting of the Raleigh County Medical Society which was held at the El Chico Restaurant in Beckley on April 16.

Doctor Amory is Professor and Chairman of the Department of Radiology at the West Virginia University School of Medicine and formerly served as Director of Radiology Service at Beckley Memorial Hospital. He presented a paper on "Pulmonary Circulation and Selective Angiocardiography in Congenital Heart Disease."

* * * *

WYOMING

The regular monthly meeting of the Wyoming County Medical Society was held at the Wyoming Hotel in Mullens on April 5. Wives of physicians were guests at the banquet.

Dr. Ward Wylie, a member of the State Senate, discussed legislative measures of interest to the medical profession.—Ross E. Newman, M. D., Secretary.

Woman's Auxiliary

to the

WEST VIRGINIA STATE MEDICAL ASSOCIATION

President: Mrs. Pat A. Tuckwiller, Charleston
President Elect: Mrs. George A. Curry, Morgantown
First Vice President: Mrs. Lysle T. Veach, Petersburg
Second Vice President: Mrs. Charles S. Harrison Clarksburg
Third Vice President: Mrs. Joe N. Jarrett, Oak Hill
Fourth Vice President: Mrs. Wilson P. Smith, Huntington
Treasurer: Mrs. Grover C. Hedrick, Jr., Beckley
Recording Secretary: Mrs. Robert J. Tchou, Williamson
Corresponding Secretary: Mrs. James T. Spencer, Charleston
Parliamentarian: Mrs. John W. Hash, Charleston

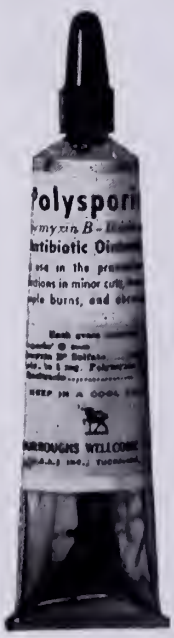
HANCOCK

The Woman's Auxiliary to the Hancock County Medical Society held its final luncheon meeting of the year at the Williams Country Club in Weirton on April 21.

Mrs. Leonard E. Yurko, the president, presided at the business meeting and submitted the annual report to the members.

Mrs. Edward A. Gretchen submitted routine reports and Mrs. E. M. Clubb, Jr., a report on mental health. Mrs. E. L. Justice was the hostess.

in treating topical infections, no need to sensitize the patient



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HARRISON

Past presidents of the Woman's Auxiliary to the Harrison County Medical Society were honored at a dinner meeting which was held at the Stonewall Jackson Hotel in Clarksburg on May 7.

The Rev. Raymond Radzieta was the guest speaker. Father Radzieta, pastor of Holy Rosary Church in Clarksburg, discussed "Communism."

Mrs. Sobisca S. Hall, a past president, installed the following new officers:

Mrs. J. D. H. Wilson, president; Mrs. A. Robert Marks, president elect; Mrs. Albin A. Galuszka, vice president; Mrs. Karl A. Dillinger, secretary; and Mrs. Boylston D. Smith, treasurer.—Mrs. Karl A. Dillinger, Press & Publicity.

* * * *

KANAWHA

Mrs. Pat A. Tuckwiller of Charleston, President of the Woman's Auxiliary to the West Virginia State Medical Association, was the guest of honor at a tea given by members of the Woman's Auxiliary to the Kanawha Medical Society at the Governor's Mansion on April 14.

Members of the Woman's Auxiliary to the Cabell County Medical Society also were guests as were Mrs. Joe N. Jarrett of Oak Hill and Mrs. Wilson P. Smith of Huntington, third and fourth vice presidents, respectively, of the Woman's Auxiliary to the State Medical Association.

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C. D. Hershey, M. D.
E. C. Voss, M. D.

Ophthalmology:
W. F. Park, M. D.
G. J. Pentecost, M. D.

Orthopedic Surgery:
C. B. Buffington, M. D.
G. B. Krivchenia, M. D.

Thoracic Surgery:
Daniel W. Dickinson, M. D.

Obstetrics and Gynecology:
Robert W. Leibold, M. D.
Robert T. Brandfass, M. D.

Urology:
Richard D. Gill, M. D.

Neurological Surgery:
James S. Rogers, M. D.
Frank M. Hudson, M. D.

Internal Medicine:
Charles H. Hiles, M. D.
Albert M. Valentine, M. D.
James A. Jacob, Jr., M. D.

Psychiatry and Neurology:
Albert L. Wanner, M. D.
Stephen D. Ward, M. D.
David H. Smith, M. D.

Roentgenology:
William K. Kalbfleisch, M. D.

Clinical Laboratories:
Nancy Fondriest, M. T.

Technologists:
Electrocardiography:
Patricia Pastor, R. N.
Electroencephalography:
JoAnn Hastings
Roentgenology:
Evelyn Forester, R. T.

Business Manager:
Lester L. Cline

In the receiving line were Mrs. Joseph A. Smith of Dunbar, president of the Woman's Auxiliary to the Kanawha Medical Society; Mrs. Tuckwiller, Mrs. W. W. Barron, wife of Governor W. W. Barron; Mrs. V. Eugene Holcombe of Charleston, a past president of the Woman's Auxiliary to the American Medical Association; Mrs. Jarrett and Mrs. Smith.

Officers elected for the current year are as follows:

Mrs. Earl A. McCowen, president; Mrs. James H. Walker, president elect; Mrs. Robert C. Ovington, first vice president; Mrs. Marshall J. Carper, second vice president; Mrs. George V. Hamrick, third vice president; Mrs. Willis D. Garrard, fourth vice president; Mrs. John R. Godbey, treasurer; Mrs. W. A. Cracraft, corresponding secretary; and Mrs. Paul C. Soulsby, recording secretary—Mrs. James H. Walker, Publicity Chairman.

* * * *

LOGAN

The Woman's Auxiliary to the Logan County Medical Society observed Doctor's Day with a dinner meeting at the Smoke House in Logan on April 5.

Mrs. Pat A. Tuckwiller of Charleston, President of the Woman's Auxiliary to the West Virginia State Medical Association, installed the following officers:

Mrs. David W. Mullins, president; Mrs. Walter E. Brewer, president elect; Mrs. Harold Van Hoose, vice president; Mrs. Thomas P. Long, treasurer; and Mrs. Lyle H. Boyea, secretary.

Mrs. V. Eugene Holcombe of Charleston, a former Logan resident and a past president of the Woman's Auxiliary to the American Medical Association, was a special guest.

Other guests included Dr. and Mrs. Wilson P. Smith of Huntington and Dr. and Mrs. Robert Tchou of Williamson. Mrs. Smith is fourth vice-president and Mrs. Tchou recording secretary of the Woman's Auxiliary to the State Medical Association.

* * * *

OHIO

The Woman's Auxiliary to the Ohio County Medical Society held its annual Doctor's Day Banquet at the Esquire Supper Club in Wheeling on April 11.

Mrs. George M. Kellas served as general chairman of arrangements. She was assisted by Mesdames James E. Spargo, George E. Strobel, George M. Kellas, Herbert G. Dickie, Jr., and James D. Bird.

* * * *

RALEIGH

The Woman's Auxiliary to the Raleigh County Medical Society held its annual Benefit Bonnet Luncheon at the Black Knight Country Club in Beckley on March 11.

More than 250 women from Beckley and vicinity attended the affair. Four dozen new Spring hats were sold at auction after the luncheon with the proceeds going to the Auxiliary's Nurses Scholarship loan fund.

Mrs. Richard G. Starr served as general chairman of the program. Mrs. Grover C. Hedrick, Jr., was in

OFFICERS OF COUNTY AUXILIARIES

Society	President		Correspondent	
Boone	Mrs. H. H. Howell	Madison	Mrs. Wyson Curry, Jr.	Madison
Cabell	Mrs. Frank M. Peck	Huntington	Mrs. C. L. Terlizzi	Huntington
Central West Virginia	Mrs. Earl L. Fisher	Gassaway	Mrs. Charles T. Lively	Weston
Eastern Panhandle	Mrs. F. A. Hamilton, Jr.	Martinsburg	Mrs. William L. Rodgers	Martinsburg
Fayette	Mrs. William L. Claiborne	Montgomery	Mrs. J. B. Thompson	Oak Hill
Greenbrier Valley	Mrs. Philip W. Oden	Ronceverte	Mrs. Robert R. Pittman	Marlinton
Hancock	Mrs. Leonard E. Yurko	Weirton	Mrs. Eli Joel Weller	Weirton
Harrison	Mrs. Paul E. Gordon	Clarksburg	Mrs. Karl A. Dillinger	Clarksburg
Kanawha	Mrs. Joseph A. Smith	Dunbar	Mrs. James H. Walker	Charleston
Logan	Mrs. David W. Mullins	Logan	Mrs. Erwin R. Chillag	Holden
Marion	Mrs. William A. Ehrgott	Fairmont	Mrs. Robert B. Hamilton	Fairmont
McDowell	Mrs. J. Hunter Smith	Welch	Mrs. John H. Murry	Gary
Mercer	Mrs. J. E. Blaydes, Jr.	Bluefield	Mrs. Richard O. Rogers, Jr.	Bluefield
Mingo	Mrs. Robert J. Tchou	Williamson	Mrs. Frank J. Burian	Williamson
Monongalia	Mrs. French R Miller	Morgantown	Mrs. John J Lawless	Morgantown
Ohio	Mrs. Herbert G. Dickie, Jr.	Wheeling	Mrs. Joseph L. Curry	Wheeling
Potomac Valley	Mrs. Robert W. Bess, Jr	Westernport, Md	Mrs. Vernon L. Dyer	Petersburg
Preston	Mrs. William H. Harriman, Jr.	Terra Alta	Mrs W. Parke Johnson, Jr.	Arthurdale
Raleigh	Mrs. John J. Marra	Beckley	Mrs John E. McKenzie	Beckley
Taylor	Mrs. Herbert N. Shanes	Grafton	Mrs Herbert N Shanes	Grafton
Wood	Mrs. Charles W. Thacker	Vienna	Mrs. Robert W Howes, Jr.	Parkersburg
Wyoming	Mrs. Byron W Steele	Mullens	Mrs. George F. Fordham	Mullens

charge of the decorations and Mrs. Warren D. Elliott the ticket chairman.

The annual business meeting of the Woman's Auxiliary to the Raleigh County Medical Society was held at the home of Dr. and Mrs. Thomas L. Martin in Beckley on April 20.

A musical program, arranged by Mrs. Warren D. Elliott, was presented on the piano and clavichord by Miss Susan Casali, Miss Joyce Gravely, Miss Mary Ratcliffe and Pat Tucker.

Mrs. John J. Marra, the president, presided at the business meeting. Final reports were given by various committee chairmen.

* * * *

WOOD

The April meeting of the Woman's Auxiliary to the Parkersburg Academy of Medicine was held at the Chancellor Hotel in Parkersburg.

The guest speaker was Mr. Frank Seibel, executive director of the new Parkersburg Boys' Club. He discussed the various facets of the organization.

The slate of officers for the coming year was announced. They are as follows:

Mrs. Lyle D. Vincent, president; Mrs. George E. McCarty, president elect; Mrs. Donald R. Lantz, first vice president; Mrs. Robert A. McDougal, second vice president; Mrs. Ira Connolly, Jr., recording secretary; Mrs. Charles B. Cobern, corresponding secretary; and Mrs. John C. Bryce, treasurer.

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Side effects: Pentaerythritol tetranitrate may infrequently cause nausea and mild headache, usually transient. Slight drowsiness may occur with meprobamate and, rarely, allergic reactions. **Precautions:** Meprobamate may increase effects of excessive alcohol. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction. **Contraindications:** Like all nitrate-containing drugs, 'Miltrate' should be given with caution in glaucoma. *Complete product information available in the product package, and to physicians upon request.* **Dosage:** 1 to 2 tablets, *before meals* and at bedtime. Individualization required. **Supplied:** Bottles of 50 tablets.

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meprobamate 200 mg. + pentaerythritol tetranitrate 10 mg.

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Book Reviews

CLINICAL INVESTIGATION IN MEDICINE (Legal, Ethical and Moral Aspects). Edited by Irving Ladimer, S. J. D., and Roger W. Newman, LL. B. Pp. 517. Law-Medicine Research Institute, Boston University, 1963.

This book is a result of a United States Public Health Service grant given to the Law Medicine Research Institute, Boston University in January, 1960. The actual publication itself was aided in large part by a grant from the Schering Foundation, Inc., Bloomfield, New Jersey. The Law and Medicine Institute of Boston University is dedicated to "the improvement of communication and cooperation between the professions of law and medicine." The contributors to this work are recognized authorities in the fields of medicine, law, toxicology, penology, and theology.

The actual volume is composed of seven major topics plus a bibliography section. Considerable interesting information is presented in a historical and ethical perspective. Codifications and principles are developed with considerable referral to the "Neuremberg code". A legal review and analysis discusses medical malpractice from the experimentation point of view. Authorities from the major religious groups discussed their various points of view as regards the individual's right as a Christian to offer himself as an experimental subject. A considerable background of information is available to those who are interested in doing clinical drug trials and the new drug legislation and regulations are spelled out in an understandable fashion. Attention is paid to the scientific design from an ethical and scientific standpoint. The ethics of use and responsibilities to normal volunteers as well as means of recruiting same are discussed. The use of children, military personnel and prisoners for experimental studies is given considerable attention.

In general, the book offers interesting historical reading and an informative and broad discussion of the legal aspects of clinical investigation. Anyone who is involved with clinical drug trials or clinical investigation would be well advised to be aware of the general subject matter contained in this work. In particular, a number of court cases are reviewed to develop the courts' past viewpoints concerning medical malpractice in experimental situations.

This is recommended reading to those physicians who have any contact with clinical research.—J. E. Jones, M. D.

* * * *

CANCER OF THE STOMACH—By William H. ReMine, M. D., M. S.; James T. Priestley, M. D., M. S.; Joseph Berkson, M. D., D. Sc.; and Members of the Staff of the Mayo Clinic. Pp. 255, illustrated. W. B. Saunders Company: Philadelphia and London. Price $11.50.

In this monograph, a brief history of carcinoma of the stomach is given, from the earlier references up to the present time. The authors have set forth the natural history, diagnosis, treatment and the results of treatment of this disease. They analyze the thinking, practice and results of a large clinical team over the years, and correlate this with the present clinical practices at the Mayo Clinic.

The book is written in clear narrative style. It is concise, but is of enough scope and detail to give the reader a grasp of the problem of carcinoma of the stomach, and a working knowledge for diagnosis and treatment of this disease.

Among the various methods of diagnosis considered are such modern techniques as gastroscopy with biopsy, and the use of fluorescing materials before gastric washing for cytologic examination. However, the authors agree that the mainstay of diagnosis is still in the hands of the radiologist who does a careful upper gastrointestinal series.

The authors state that the early symptoms are vague, but when the diagnosis is made when these symptoms alone are present, the survival time is greatly increased. We are reminded that frequently carcinoma of the stomach is already inoperable at the time major symptoms appear. Early diagnosis, followed by the surgical removal of all the tumor is the key to successful treatment and long-term survival.

The sarcomas and lymphomas are discussed in some detail for, although relatively few in number, they offer a better prognosis and some may respond to irradiation.

The natural course of carcinoma is taken up, including the size, type and location of the tumor, means of spread and the significance of such factors as age, sex, achlorhydria, pernicious anemia and gastric ulcer

A study of the surgical techniques used in the removal of the tumors and the primary lymphatic areas is reported. A chapter is included on total gastrectomy, and another is devoted to palliative treatment including surgical procedures.

This book, while noting the decrease in the incidence of carcinoma of the stomach in the United States, laments the fact that the improvement in the survival rate is not as great as one would desire in the presence of modern diagnostic and surgical techniques.

For the physician who first sees the patient, and for the surgeon who treats him, this little book will find a significant place of usefulness.—Josiah Thompson, M. D.

New Saunders Books

W. B. Saunders Company features the following recent books in their full-page advertisement appearing on page iii in this issue:

Child—"The Liver and Portal Hypertension." The first in a series of monographs on selected major problems in clinical surgery. Covers all aspects of the subject.

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JULY
1964

Vol. 60 No. 7

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Official Organ of the West Virginia State Medical Association

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Member 1964

CONTENTS

Scientific Articles

Pleural Mesothelioma (Report of Two Cases: One Benign and One Malignant)—Victor M. Napoli, M. D. 173

Etiological Factors in Acne—Robert E. English, M. D., and Joseph A. Witkowski, M. D. 178

Special Article

A Doctor Looks at Shakespeare—Bernard W. Wilkinson, M. D. 182

The President's Page

Points to Ponder—Charles L. Goodhand, M. D., President, West Virginia State Medical Association 188

Editorials

Medical School Graduates and Population 189

Shakespeare and Medicine 190

General News

Program Completed for Annual Meeting 191

New Officers of W. Va. Chapter, AAGP 192

Students Selected for Scholarships 194

Dr. William L. Cooke Heads NTA 195

New Officers of Medical Assistants Assn. 196

Dr. Charles A. Hoffman AUA Treasurer 197

Allergy Program at The Greenbrier 198

Special Departments

WVU Medical Center News xxi

The Month in Washington xxiv

County Societies xxvii

The Woman's Auxiliary xxviii

Correspondence xxxiii

Book Reviews xxxiv

Directory of Physicians in Limited Practice xxxvii

Index to Advertisers xl

In Sprains, Strains and Muscle Spasm, 'Soma' Compound

numbs the pain...not the patient

A potent analgesic and
a superior muscle relaxant

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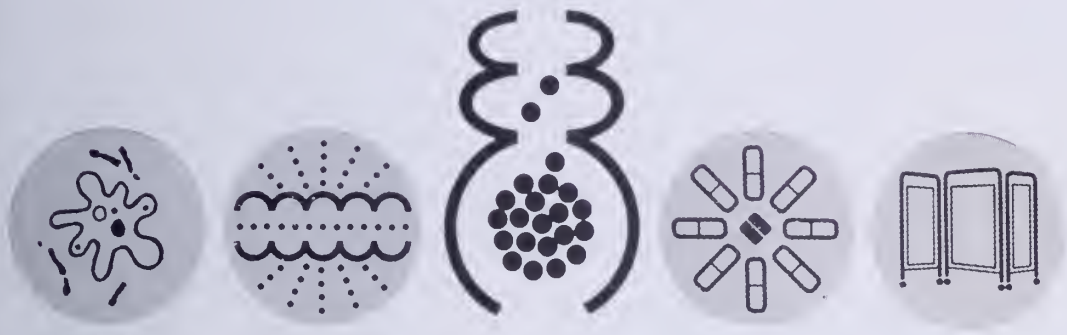

Gastroenteritis Functional diarrhea Drug-induced diarrhea Postsurgical diarrhea

Lomotil controls the basic physiologic dysfunction in diarrhea—excessive propulsive motility. Pharmacologic evidence indicates that it does so by directly inhibiting propulsive movements of the intestines. This direct, well-localized activity controls diarrheas of widely varied origin and does so promptly, conveniently and economically.

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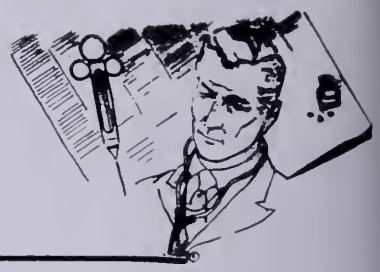
Research in the Service of Medicine SEARLE

WVU Medical Center
–News–



• **Compiled from material furnished by Howard Lewis, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

THE third recipient of a scholarship awarded annually by the West Virginia State Medical Association to a student enrolled in the West Virginia University School of Medicine was among the 40 students who received their M. D. degrees at commencement exercises in Morgantown on June 1.

Dr. Glenn Buchanan of Gilbert, Wyoming County, received the scholarship at the beginning of his four-year training in 1960. The four-year scholarship was worth $4,000.

He will serve his internship at the Cabell-Huntington Hospital in Huntington.

Doctor Buchanan, the son of Mr. and Mrs. Blaine Buchanan of Gilbert, attended public schools in Wyoming County and took his pre-medical training at Berea College in Kentucky.

Dr. Larry Hemmings of Charleston, recipient of the first State Medical Association scholarship in 1958, received his M. D. degree in 1962 and is now serving in the Medical Corps of the United States Navy.

Dr. Terry T. Tallman of Alma, Tyler County, recipient of the second scholarship, received his M. D. degree in 1963 and served his internship at the West Virginia University Hospital in Morgantown. He recently entered the Medical Corps of the United States Air Force.

Scholarships were awarded to Clare D. Edman of Parkersburg in 1961; to Paul Brooks of Sissonville and Paul Lanham of Charleston in 1962; to J. Donald Morrison of Huntington and Richard L. Hess of Clarksburg in 1963; and in 1964 to Carl E. Nichols of Glenville and Byron L. Van Pelt of Bethany.

Former Governor Addresses Graduates

Former Governor Okey L. Patteson of Mount Hope delivered the principal address at ceremonies honoring the third class of graduates from the WVU School of Medicine.

It was during the term of office of Governor Patteson that the Medical Center was authorized and its planning begun. On October 10, 1960, he and former WVU President Irvin Stewart formally presented University Hospital to the State and West Virginia University.

The address to the 40 students, who formally received M. D. degrees on June 1, was on the general theme of what the citizen expects of a physician.

Boston Physician Presents AOA Lecture

Dr. Robert J. Glaser, president of Affiliated Hospitals Center, Inc., in Boston and Professor of Social Medicine at the Harvard Medical School, presented the annual Alpha Omega Alpha Lecture at the WVU School of Medicine on May 21.

A former Dean and Professor of Medicine at the University of Colorado School of Medicine, Doctor Glaser discussed "A Perspective in Medical Education."

Eight students and one faculty member were initiated into the WVU Chapter of the Society. The seniors were Susan S. Gustke of New Cumberland; David R. Hobbs, W. Scott Bowie and Louis A. Fabian of Morgantown; and Richard H. Garretson of Huntington.

Also honored were Dr. Russell V. Lucas, Jr., Associate Professor of Pediatrics, and C. Marshall Neptune of Fairmont, Norman P. Silvers of Flushing, New York, and Alexander J. Sabo of Morgantown, all members of the junior class.

Cross Presented for Chapel

The Morgantown Kiwanis Club recently presented a brass cross to the All-Faiths Chapel at the WVU Hospital. Arrangements for the gift were made through Dr. Eldon B. Tucker of Morgantown, who serves as chairman of the service club's Church and Spiritual Aims Committee.

Doctor Tucker said that the organization has purchased hymnals for the chapel. An extensive program, in cooperation with the area ministerial association, is planned to help expand the religious aspects and services available to both patients and visitors at the hospital.

Doctor Penrod Honored

Dr. Kenneth E. Penrod, WVU Vice President and Director of the Medical Center, has been appointed to an advisory committee for a study of medical education in developing nations of the world. The committee was set up within the Association of American Medical Colleges under a contract with the Agency for International Development of the U. S. State Department.

One of the committee's purposes is to clarify basic issues as to the role of United States Medicine, medical schools in this country and the U. S. Government in the advancement of medical education in developing countries.

Outwardly calm...but what goes on inside?

Appearances on the outside do not necessarily suggest what goes on inside. This is particularly true of the ulcer patient, who may appear jolly and unruffled to his neighbors, but presents to you the classic symptoms: organic and functional disorders of the G.I. tract, associated with anxiety and tension.

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313-4

The Month in Washington

A new Food and Drug Administration regulation requires manufacturers to submit proof of effectiveness of drugs cleared between 1938 and June 20, 1963, and still on the market. This retroactive regulation was the most controversial of a group of new drug regulations issued under the Kefauver-Harris FDA Act amendments enacted into law in 1962.

The Pharmaceutical Manufacturers Association said the government was "making a mistake in blanketing in drugs which have been regarded as old, safe and effective." The PMA questioned whether the FDA "has put too broad an interpretation on the 1962 drug amendments." In protesting such a regulation before it was issued in final form, the PMA said a retroactive regulation would comprise "such sweeping requests for information as to be unreasonably burdensome on the industry . . . and ultimately on the Food and Drug Administration."

"The consumption of manpower, particularly of scarce, highly trained scientific personnel, that would be required to comply with the proposed regulations is staggering and bears no reasonable relationship to any possible benefit to the public," the PMA said:

"In fact the demand on the time of the scientific personnel of our member companies would be of such magnitude that it would impede and delay clinical research and the development of new drugs. Needless to say such a result would not be in the public interest."

Drug manufacturers had argued that so-called "grandfather rights" allowed them to continue to make claims contained in new drug applications cleared in the past, and that they should not now have to produce medical evidence to support these claims.

The FDA disagreed. It held that Congress, in passing the drug amendments in 1962, specifically made it the agency's duty to review all medical claims for "new drugs" cleared in the past on safety alone, "with the intention that any claim unsupported by substantial medical evidence should be discontinued after next October."

The FDA held that the "grandfather clause" gives the right to make unsupported claims for only two classes of drugs: (1) those on the market before 1938 and therefore exempted from new-drug clearance by the 1938 Act, and (2) those introduced after 1938 which were generally recognized as safe and therefore were never cleared as "new drugs."

"We are glad that Congress has given us this unique opportunity to review past medical decisions permitting several thousand new drugs to go on the market. This review will include not only a new look at the safety of these drugs, but a first-time comparison of the actual promotional claims with the medical evidence on which they are based," FDA Commissioner George P. Larrick said.

• **From the Washington Office of the American Medical Association.**

Boisfeuillet Jones Resigns HEW Post

Boisfeuillet Jones resigned as Special Assistant to the Secretary of Health, Education and Welfare effective June 30. Jones told President Johnson in his letter of resignation that when he began the job as Special Assistant for Health and Medical Affairs in January, 1961, he expected to stay about two years, but challenges in the position kept him there longer.

"I shall return now to private life in Atlanta," Jones said, "in a unique situation which will permit me to engage in a wide range of philanthropic activity, including health, education, and welfare with which my interests have long been identified."

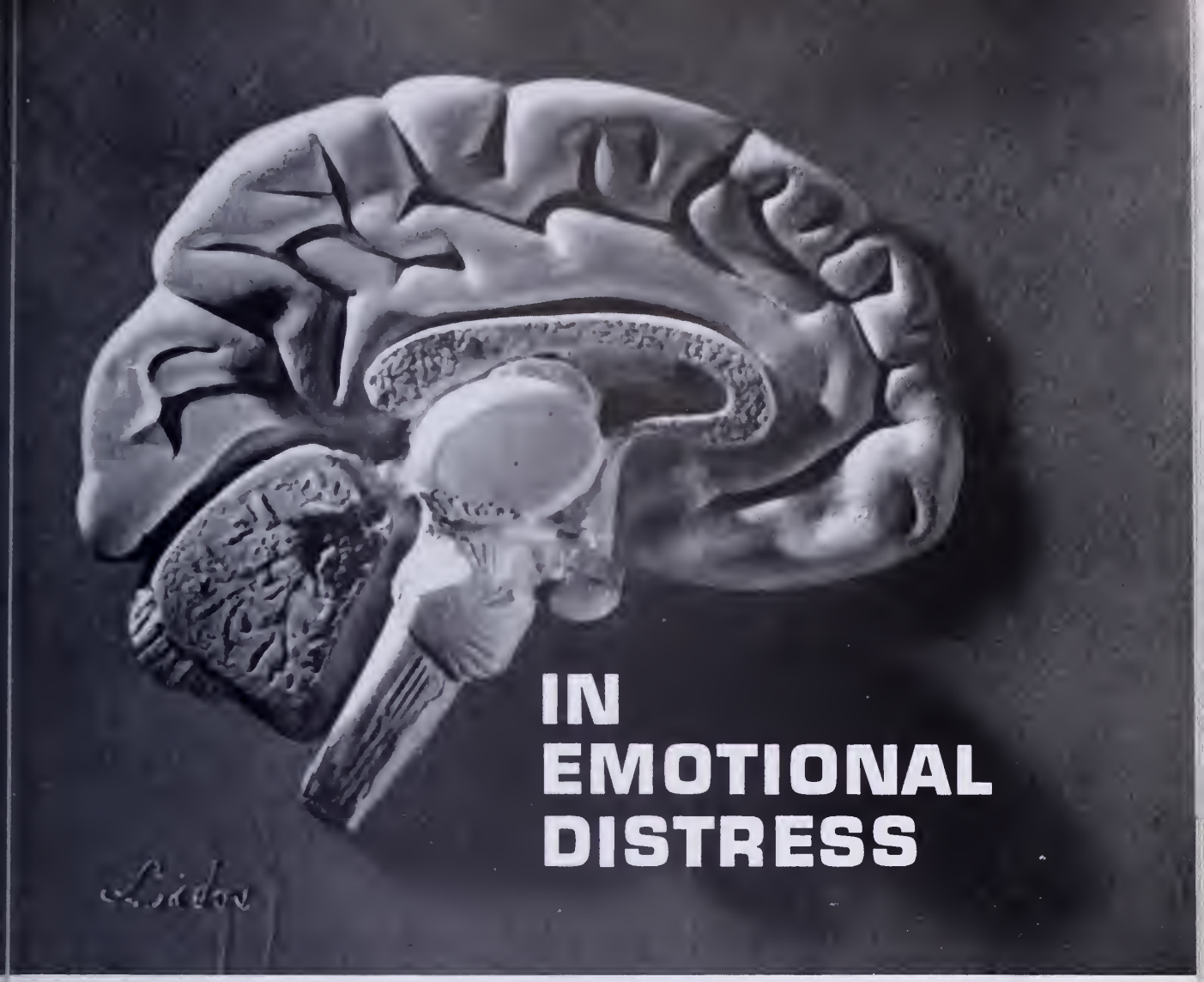
Johnson replied that he acceded with reluctance to Jones' wish to return to private life. Jones had been considered influential in HEW policy matters and often had been spokesman for the department and HEW Secretary Anthony J. Celebrezze. There was no advance indications that Jones would leave the department and his resignation came as a surprise.

Reversal in Declining Birth Rate Anticipated

The Public Health Service has reported that the nation's birth rate has been declining steadily for the past two years. But the PHS anticipated a reversal of the downward trend. There were 49,000 fewer births in the United States during the year ended March 31, 1964, than in the previous 12 months. The 337,000 births registered in this March was the smallest number for the month since 1955..

An increase in marriages in March—to a total of 109,000—was interpreted as foreshadowing a reversal in the decline in the birth rate.

"The marriage trend," the PHS said, "is now showing signs of increase, but it would take some time for this to affect the birth rate. The age composition of the female population, with increasing numbers of women entering the childbearing ages, is also favorable to a higher level of fertility."



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Simplified, convenient dosage for emotional relief.

effects: 'Meprospan' (meprobamate, sustained release) markably free of untoward reactions. Daytime drowsiness not been reported. Rare allergic or idiosyncratic reactions occur, generally developing after 1-4 doses of the drug.

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Obituaries

WILLIAM BYRD HUNTER, M. D.

Dr. William Byrd Hunter, 80, formerly of Huntington, died on May 13 at a VA Hospital in Coral Gables, Florida.

Doctor Hunter was born at Dry Creek in Raleigh County, June 21, 1883, the son of Lewis and Arminta H. Hunter. He attended the two-year School of Medicine at West Virginia University and received his M. D. degree in 1910 from the College of Physicians and Surgeons in Baltimore.

He served an internship at Children's Hospital in Baltimore before practicing four years on the Pribilof Islands in Alaska.

Doctor Hunter served in the Medical Corps of the United States Army on the Mexican Border and during World Wars I and II, retiring in 1945 with the rank of Lt. Colonel.

After World War I he did postgraduate work in pediatrics at Harvard Medical School before returning to Huntington where he practiced until 1949 with the exception of four years service during World War II.

Doctor Hunter, who served for many years on the teaching staff of St. Mary's Hospital in Huntington, was an honorary life member of the Cabell County Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by a brother, Dr. H. R. Hunter of Whitesville, and a sister, Minnie Hunter Wright of Miami, Florida.

* * * *

JOSEPH CHARLES PECK, M. D.

Dr. Joseph Charles Peck, 81, of Moundsville, died on May 25 at his home in that city.

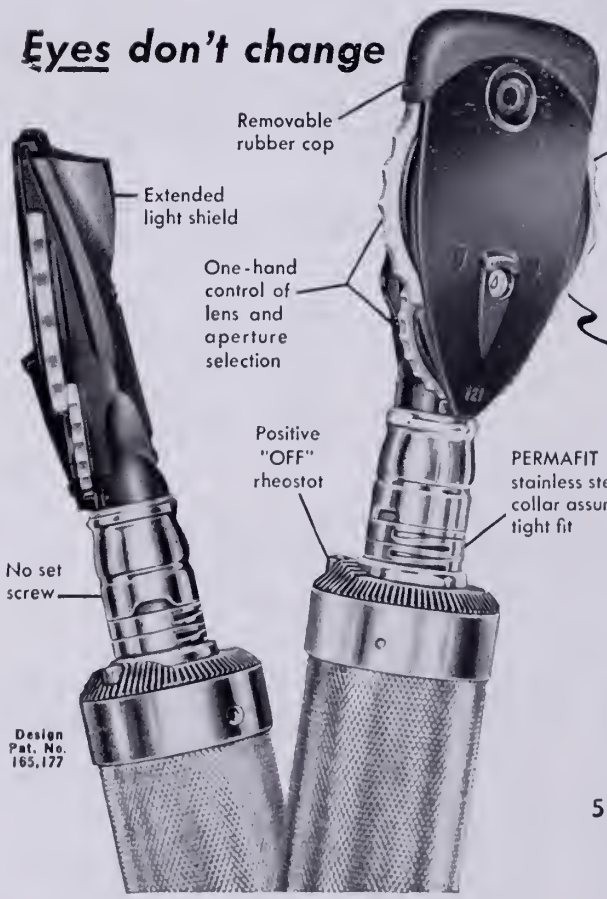
Doctor Peck was born June 14, 1882, at Pecks Mill, Logan County, the son of John Edwin and Mary Elizabeth Norvelle Peck. He attended the two-year School of Medicine at West Virginia University and received his M.D. degree in 1907 from the College of Physicians and Surgeons of Baltimore, the same year he was licensed to practice in West Virginia.

He practiced in Huntington and Madison before moving in 1909 to Moundsville where he later served a term as president of the Marshall County Medical Society.

Doctor Peck became a member of the West Virginia State Medical Association in 1911 and in 1948 was made an honorary life member of the Marshall County Medical Society, the State Medical Association and the American Medical Association.

He is survived by one sister, Mrs. Lula Harris of Logan, and two nephews, Dr. Edwin Harris of Logan and Ted Peck of Moundsville.

Eyes don't change ... but instruments do



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County Societies

CABELL

Dr. Benjamin Rush, Jr., of Lexington, Kentucky, was the guest speaker at the regular monthly meeting of the Cabell County Medical Society which was held at the Hotel Frederick in Huntington on May 14.

Doctor Rush, who is a member of the Department of Surgery at the University of Kentucky College of Medicine, presented an interesting paper on the use of regional perfusion in the chemotherapy of malignant disease. A color film showed dramatic, if temporary, improvement in several patients with far-advanced cancer.

Dr. Clarence H. Boso, the president, presided at the business meeting and Dr. Walter R. Wilkinson presented a report of a recent meeting of the Joint Conference Committee of the State Medical Association with the Department of Welfare—W. L. Neal, M.D., Secretary.

* * * *

McDOWELL

Dr. Charles L. Goodhand of Parkersburg, President of the West Virginia State Medical Association, was the guest speaker at the regular monthly meeting of the McDowell County Medical Society which was held at Stevens Clinic Hospital in Welch on May 13.

Doctor Goodhand, who was introduced by Dr. A. J. Villani, gave a very enlightening and warm talk on the problems of organized medicine today. Following his formal presentation, Doctor Goodhand answered questions from the 21 members who attended the meeting.

Dr. John S. Cook, the president, presided at the business meeting. Drs. Robert E. Dye and J. R. Hatfield were unanimously elected to membership in the Society.—David J. Skewes, M. D., Secretary.

* * * *

MERCER

Dr. Charles L. Goodhand of Parkersburg was the guest speaker at the regular monthly meeting of the Mercer County Medical Society which was held at the West Virginian Hotel in Bluefield on April 20.

Doctor Goodhand, President of the State Medical Association, presented an interesting talk on the various problems confronting the profession.

During the business meeting, Dr. Frank J. Holroyd was named chairman of a committee to consider disposition of funds realized from the polio clinics. Dr. P. R. Fox was named a member of the Committee on Medicine and Religion and the Society approved a contribution to Camp Kno-Koma.—J. Brookins Taylor, M. D., Secretary.

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Parliamentarian: Mrs. John W. Hash, Charleston

EASTERN PANHANDLE

Mrs. L. Walter Fix of Martinsburg was elected president of the Woman's Auxiliary to the Eastern Panhandle Medical Society at a meeting which was held at the Wayside Inn in Middletown, Virginia, on May 13. She succeeds Mrs. F. A. Hamilton, Jr., of Martinsburg.

Other officers named were as follows:

Mrs. Thomas H. McGavack, president elect; Mrs. Daniel E. Hendricks, vice president; Mrs. James L. Ghaphery, recording secretary; Mrs. E. Walter Rice, corresponding secretary; and Mrs. V. L. Glover, treasurer.

FAYETTE

Mrs. Ivan H. Bush, Jr., was installed as president of the Woman's Auxiliary to the Fayette County Medical Society at its regular monthly meeting which was held at the White Oak Country Club near Oak Hill on May 11. She succeeds Mrs. William L. Claiborne of Montgomery.

Other officers installed for the coming year were as follows:

Mrs. Thomas Kerr Laird, president elect; and Mrs. J. B. Thompson, secretary-treasurer.

Mrs. Bush and Mrs. Joe N. Jarrett presented a report on the annual Spring Board Meeting of the Executive Board of the Woman's Auxiliary to the West Virginia Medical Association which was held in Charleston, April 28-29.

* * * *

KANAWHA

Mrs. Earl A. McCowen was installed as President of the Woman's Auxiliary to the Kanawha Medical Society during the regular monthly meeting which was held on May 12 at the home of Dr. and Mrs. Daniel A. Mairs in Charleston.

Other new officers for the coming year are as follows:

Mrs. James H. Walker, president elect; Mrs. Robert C. Ovington, first vice president; Mrs. Marshall J. Carper, second vice president; Mrs. George V. Hamrick, third vice president; Mrs. Willis D. Gerrard, fourth vice president; Mrs. John R. Godbey, treasurer; Mrs. Wil-

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liam A Cracraft, corresponding secretary; and Mrs. Paul C. Soulsby, recording secretary.

The installation was conducted by Mrs. Pat A. Tuckwiller, President of the Woman's Auxiliary to the State Medical Association.

Miss Dorothy Brooks, Director and Assistant Professor of Nursing Education at Morris Harvey College, was the guest speaker.—Mrs. James H. Walker, Publicity Chairman.

* * * *

MERCER

The annual installation tea of the Woman's Auxiliary to the Mercer County Medical Society was held at the home of Dr. and Mrs. J. E. Blaydes, Jr., in Bluefield on May 18.

Prior to the installation, a business meeting was conducted with Mrs. Blaydes, the outgoing president, presiding. Reports were presented by Mrs. James E. McGee, Jr., Mrs. R. S. Gatherum, Jr. and Mrs. A. C. Van Reenen. Mrs. Blaydes also read a letter of commendation and appreciation from Mrs. Pat A. Tuckwiller of Charleston, President of the Woman's Auxiliary to the West Virginia State Medical Association.

Mrs. Charles S. Flynn presided at the installation of the following officers:

Mrs. Joe E. McCary, president; Mrs. C. D. Pruett, president elect; Mrs. John J. Mahood, vice president; Mrs. James E. McGee, Jr., secretary; Mrs. Richard O. Rogers, Jr., treasurer; and Mrs. L. J. Pace, corresponding secretary.

MONONGALIA

Mrs. Arthur W. Kelley was installed as president of the Woman's Auxiliary to the Monongalia County Medical Society at its regular monthly meeting which was held at the Lakeview Country Club in Morgantown on May 4. She succeeds Mrs. French R. Miller, who presided at the installation.

Other new officers are as follows:

Mrs. Charles E. Andrews, president elect; Mrs. W. M. Warman, vice president; and Mrs. Maynard P. Pride, treasurer.

Special guests at the meeting were Mrs. Clare Edman and Mrs. Norman Silver, members of Caduceanns, medical student wives group at West Virginia University.

It was announced at the conclusion of the meeting that the Auxiliary had contributed $500 to the AMA-ERF fund.

* * * *

OHIO

Mrs. Pat A. Tuckwiller of Charleston, President of the Woman's Auxiliary to the West Virginia State Medical Association, installed new officers of the Woman's Auxiliary to the Ohio County Medical Society at the annual Inaugural Luncheon which was held at the Wheeling Country Club on May 26.

Mrs. Tuckwiller installed Mrs. C. B. Buffington as the new president succeeding Mrs. H. G. Dickie, Jr.

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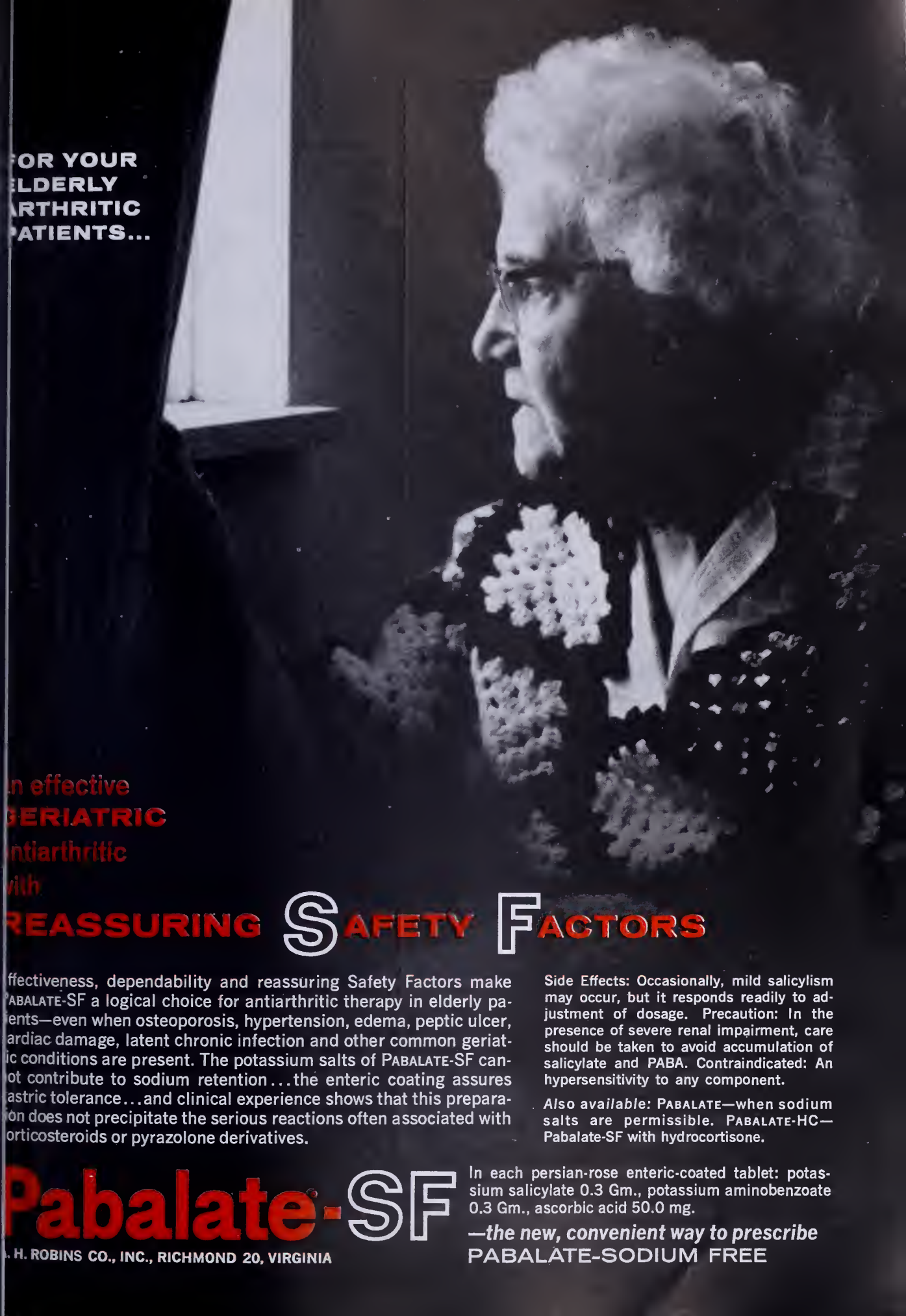
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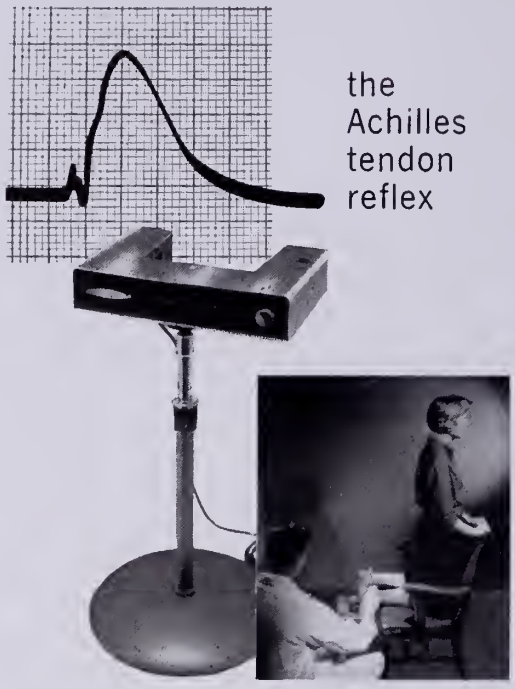

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Other new officers are as follows:

Mrs. Herman Rubin, president elect; Mrs. Donald H. Hofreuter, vice president; Mrs. Bradford McCuskey, recording secretary; Mrs. W. Carroll Boggs, corresponding secretary; and Mrs. Howard R. Sauder, treasurer.

Mrs. Charles S. Harrison, second vice president of the State Auxiliary, and Mrs. Paul E. Gordon, both of Clarksburg, also were guests at the luncheon.

Mrs. Ross O. Bell, Jr., was luncheon chairman. She was assisted by Mesdames A. J. Niehaus, Charles T. Lenton, Jr., William P. Sinclair, Robert T. Brandfass and Harry S. Weeks, Jr.

* * * *

RALEIGH

Mrs. Charles W. Merritt was installed as president of the Woman's Auxiliary to the Raleigh County Medical Society at its regular monthly meeting which was held at the Beckley Hotel in Beckley on May 18. She succeeds Mrs. John J. Marra.

Other officers installed by Mrs. Ross P. Daniel were as follows:

Mrs. Warren D. Elliott, president elect; Mrs. Thomas L. Martin, vice president; Mrs. Nicholas D. Zambos, treasurer; Mrs. Albert D. Kistin, recording secretary; and Mrs. Walter E. Klingensmith, corresponding secretary.

Mrs. R. G. Broaddus gave a brief history of the Auxiliary and presented a scrapbook recording the past year's activities to Mrs. Marra.

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Correspondence

State of West Virginia
VOCATIONAL REHABILITATION DIVISION
State Board of Vocational Education
Charleston 5, West Virginia

June 2, 1964

Dr. Charles L. Goodhand
West Virginia State Medical Association
401 Atlas Building
P. O. Box 1031
Charleston 24, West Virginia

Dear Dr. Goodhand:

I am writing you the following letter concerning the confidentiality provisions of the Social Security Act in the hope that you will publish the letter in *The West Virginia Medical Journal* so that this information can reach as many as possible of the practicing physicians in West Virginia.

By virtue of Section 1106 of the Social Security Act, confidentiality attaches to all medical and non-medical information obtained in the administration of the old-age, survivors, and disability insurance programs, except as provided by regulations. Social Security Administration Regulation No. 1 sets forth the circumstances under which such information may be disclosed, and the persons or agencies to whom such information may be released. We are writing to suggest how you should handle requests for information about persons whom you have examined in connection with their claims for Social Security benefits and to advise you of the legal assistance which is available to you to help preserve the confidentiality of this information.

As provided in Regulation No. 1, medical information about disability claimants may be disclosed only for purposes related to the administration of the Act and of related programs, such as Federal pension, benefit and welfare programs and State public welfare programs receiving grant-in-aid funds under the Social Security Act. Medical information is also permitted to be released to physicians or medical institutions for treatment purposes. The patient's authorization is required in order that information may be released for any of the above purposes.

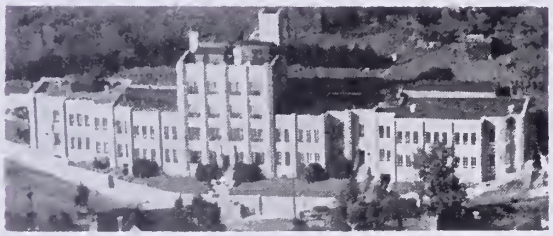
Since the confidentiality provisions of the law and regulations are applicable to physicians who examine claimants at government expense, you may find that it will save you time and trouble to refer to this agency any requests for information about disability claimants.

The provisions of the law and regulations pertaining to the confidentiality of medical information apply even if such information is sought by subpoena. The use of subpoenas to compel release of information by physicians who have performed examinations for this program has been rare. Usually, the person requesting the information is not fully aware of the provisions of the law and regulations and, upon explanation, will withdraw his request. However, if he indicates an intention to serve you with a subpoena or you are actually served with a subpoena to appear in a court or before an administrative tribunal for the purpose of testifying or producing a report of your examination of a disability claimant, please contact us at once, preferably by telephone. Upon receipt of such advice from you, we will arrange for a Federal attorney or other official to assist you in every way possible. Unless you are notified to the contrary, you should, however, arrange to appear before the body which issued the subpoena, at the appointed time. A Federal attorney will usually be present to counsel and represent you. In the rare instance where a Federal attorney may not be present, you should respectfully decline to produce any records or to testify concerning them or your examination of the claimant, directing the court's or tribunal's attention to Section 1106 of the Social Security Act and to Social Security Administration Regulation No. 1.

If you have any questions about the information given you in this letter, or any comments which you wish to make about this or related matters, we will be glad to hear from you.

Sincerely yours,

(Signed) Kenneth L. Clark, M. D.
Chief Medical Consultant
Disability Determination
Section



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Book Reviews

TEXTBOOK OF OTOLARYNGOLOGY—By David D. DeWeese, M. D., Professor and Chairman of the Department of Otolaryngology, University of Oregon Medical School, Portland, Oregon, and William H. Saunders, M. D., Professor and Chairman of the Department of Otolaryngology, The Ohio State University College of Medicine, Columbus, Ohio. Pp. 523. The C. V. Mosby Company, St. Louis, 1964. Price $9.25.

The new edition of "Textbook of Otolaryngology" by Drs. DeWeese and Saunders should be a very welcome addition to the library of physicians practicing general medicine who encounter and must treat patients with otolaryngological problems. As the subject of otolaryngology is rather notoriously being glossed over and crowded to the side in many of today's medical schools, this text will be an excellent reference for the new practitioner who finds that his practice has a greater proportion of ENT problems than the proportionate time the subject was given in medical school.

This second edition covers very well the many every day diagnostic and therapeutic problems encountered in private practice and will offer to the practitioner very practical assistance, particularly when specialists in the field are not available or are limited in supply and in their capacity to meet the demands for care of patients with ENT problems. The text is well illustrated and well organized in its method of presentation to afford ready grasp of what is expeditious in the management of many very special problems.

With such great strides in the realm of otology being made in diagnosis and in the medical and surgical treatment of ear disorders, the text readily informs one of the current knowledge in this phase of otolaryngology. Communication between people depends on good hearing and speech and all physicians should concern themselves with the early recognition of problems in these areas. The best treatment of deafness is prevention which entails early recognition of disorders of the ears, especially in children in whom early damaging conditions frequently progress without complaints from the child.

Practitioners buy this book! Refer to it frequently. —James T. Spencer, M. D.

Books Received

PEDIATRIC THERAPY—By Harry C. Shirkey, B. S. (Pharm.), M. D., F. A. A. P. (Editor). Pp. 1144, with illustrations. The C. V. Mosby Company, 3207 Washington Boulevard, St. Louis 3, Mo. 1964, First Edition. Price $16.50.

* * * *

A SAVAGE PLACE—By Frank G. Slaughter, M. D. Pp. 248. Doubleday & Company, Inc., 575 Madison Avenue, New York 22, N. Y. 1963. Price $4.50.

* * * *

CASE STUDIES IN OBSTETRICS AND GYNECOLOGY—By F. Jackson Stoddard, M. D. Pp. 312. Illustrated. Published: February 24, 1964, W. B. Saunders Company, Philadelphia. Price $8.50.

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AUGUST
1964

Vol. 60 No. 8

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CONTENTS

Scientific Articles

Small Series of Lymphograms With Clinical Applications—Fernando Dominguez, M. D., Charles C. McKay, M. D., and Hans Dransfeld, M. D. 199

Primary Varicella Pneumonia—George E. Farrell, M. D., and Arthur M. Benshoff, M. D. 203

The Practicing Physician and Community Psychiatric Efforts—William F. Sheeley, M. D. 205

The President's Page

Thoughts in Retrospect—Charles L. Goodhand, M. D., President, West Virginia State Medical Association 210

Editorials

We'll See You At The Greenbrier 211

Graduate Training in The Basic Sciences 212

General News

The Convention Program 214

W. Va. Heart Assn. Meeting 218

Proceedings of AMA Meeting 220

The Woman's Auxiliary Program 224

Convention Speakers 231

Delegates and Alternates 237

Exhibits 241

Annual Reports 247

Special Departments

WVU Medical Center xxvi

The Month in Washington xxviii

Obituaries xxx

County Societies xxxii

The Woman's Auxiliary xxxiv

Book Reviews xxxvi

Directory of Physicians in Limited Practice xli

Index to Advertisers xliv

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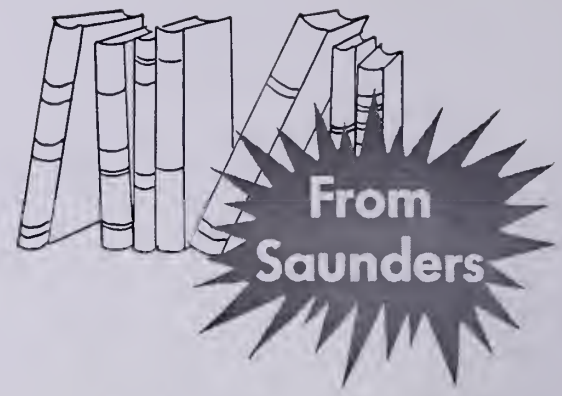

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Edited by Waldo E. Nelson, M.D., D.Sc., Professor of Pediatrics, Temple University School of Medicine; Medical Director of St. Christopher's Hospital for Children. With 81 distinguished contributors. About 1610 pages, 7" x 10", with 171 figures. About $18.00. *New (8th) Edition—Just Ready!*

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By Frank A. Elliott, M.D., F.R.C.P., Chief of Neurology, The Pennsylvania Hospital; Professor of Clinical Neurology, University of Pennsylvania School of Medicine. About 672 pages, 6¾" x 9¾", with about 179 illustrations. About $12.00. *New—Just Ready!*

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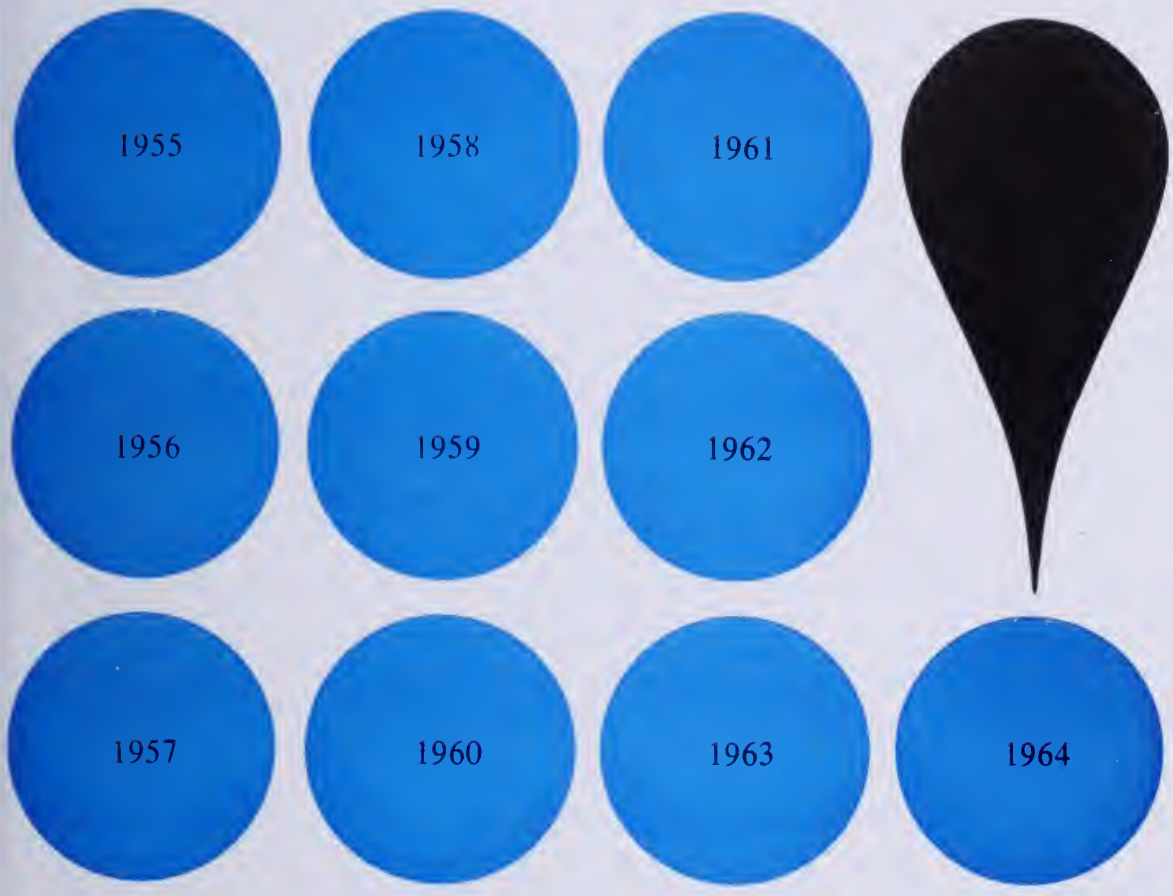

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE House Ways and Means Committee handed the Administration a defeat by refusing to act this year on the controversial King-Anderson plan for a compulsory social security hospital-medical program for the aged.

However, King-Anderson supporters expressed the hope the Senate would add the proposal to a flat social security cash benefit and tax increase bill adopted by the Ways and Means panel.

Rep. Cecil King, D-Calif., a committee member and a sponsor of the King-Anderson bill, conceded the bill did not have enough votes to pass in committee. "I don't want ever to have an adverse vote," he told reporters.

In addition to blocking King-Anderson, the Ways and Means Committee decided to take no action on proposed changes in the Kerr-Mills program of federal aid to states for health care benefits for the elderly who need financial assistance to pay hospital and medical bills.

First Increase in Six Years

The five per cent boost in the current maximum $127 monthly payment for retired social security beneficiaries would be the first social security cash increase in six years. It is designed to keep the pension payments abreast of the cost of living. The increased benefit would be financed by a tax rise that, in addition to already-slated tax boosts, would bring the social security levy by 1971 to 4.8 per cent paid by both worker and employer on the first $5,400 of salary. Present tax is 3.625 per cent on $4,800. The benefits would add up to an extra $1 billion a year.

The first motion before the committee was to increase benefits by six per cent, but Rep. King urged the King-Anderson supporters on the Democratic side of the panel to oppose this on grounds it would bring the social security tax so high it would be difficult to attach King-Anderson and even higher taxes to social security.

Other social security changes in the legislation would:

Extend social security to an estimated 150,000 self-employed physicians.

Allow widows to receive benefits at age 60 instead of 62 with a slight cut in payments.

Continue payments to widows with dependent children in school until the children reach age 22 instead of 18.

Commenting on the Ways and Means action, Dr. Norman A. Welch, president of the American Medical Association, declared the committee "acted wisely and responsibly" in refusing to approve the King-Anderson bill.

In a statement, he declared:

"We are confident that this decision is in keeping with the attitude of the majority of the American people toward this legislation, as reflected in numerous surveys by members of Congress and by private opinion sampling organizations."

Dr. Welch said, "we have opposed King-Anderson legislation because it would force heavy payroll tax increases on the nation's workers and their employers to provide hospitalization benefits indiscriminately to all the elderly, the wealthy and the well-to-do included."

Drug Industry to Challenge FDA

The drug industry decided to challenge in court the controversial Food and Drug Administration regulation requiring drug makers to produce proof of efficacy for virtually all new drugs approved since 1938, in addition to other provisions.

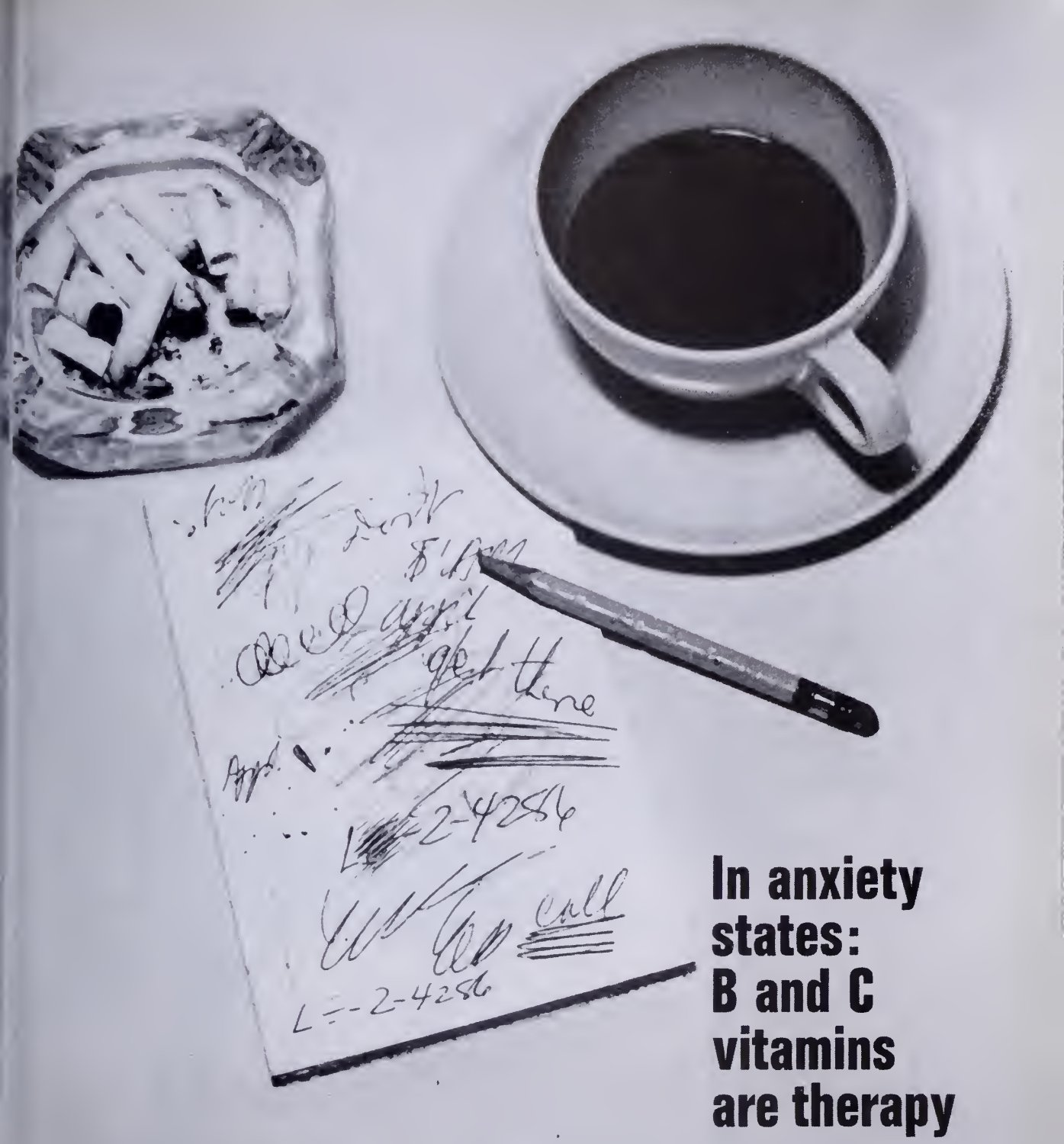
The industry has argued that Congress intended for the law to apply only to new drugs since enactment of the legislation. The FDA asserted that "what Congress intended was a comprehensive review of all drugs now on the market as a result of new drug clearance."

Change in Military Care Recommended

The American Medical Association recommended that retired military personnel receive health care benefits under a contributory private health insurance plan similar to that now in operation for civilian Federal workers.

Dr. Reuben A. Benson, chairman of the AMA Council on National Security, told a House Armed Services Subcommittee that by 1980 it is estimated that the number of retired military will reach 4,397,000. "Any health care program devised or conceived must be sufficiently elastic and effective to adjust to these demands," he noted.

He said the AMA recommends the adoption of a plan patterned after the Federal Employes Health Benefits Program. "It is the AMA's opinion that to the maximum extent possible, this care should be provided by civilian physicians in civilian facilities," Dr. Benson testified. "The Association, however, recognizes that the retiree and his dependents may be authorized the use of military facilities but recommends that such use be limited to present military facilities on a space-available basis."



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Obituaries

CHARLES G. POLAN, M. D.

Dr. Charles G. Polan, 54, of Huntington, died on June 13 at a hospital in that city.

He was born in Charleston, April 9, 1910, the son of the late A. I. and Rachael Leah Polan. He was graduated from West Virginia University and attended the two-year School of Medicine there. He received his M. D. degree in 1935 from Rush Medical College in Chicago and a Ph. D. in Neurology and Psychiatry in 1941 from the University of Minnesota Medical School in Minneapolis.

Doctor Polan, who was certified in Neurology and Psychiatry, was president of the Section on Neurology, Neurosurgery and Psychiatry of the West Virginia State Medical Association. During World War II he served in the Medical Corps of the United States Army in the European Theatre of Operations.

He was a member of the Cabell County Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by one daughter, Miss Patricia Polan of Huntington; three brothers, Dr. Meyer Polan and J. B. Polan, both of Ashland, Kentucky, and Dr. H. K. Polan of Charleston; and two sisters, Mrs. Simon Meyer of Charleston and Miss Edith Polan of Ashland, Kentucky.

* * * *

OTIS EPHRAIM REYNOLDS, M. D.

Dr. Otis Ephraim Reynolds, 91, of Huntington, died on June 24 at his home in that city following a long illness.

He was born on October 25, 1872, at Proctorville, Ohio, the son of William and Elizabeth McCallister Reynolds. He attended Marshall University and received his M. D. degree in 1901 from the Medical College of Ohio in Cincinnati.

Doctor Reynolds was licensed to practice in West Virginia in 1903 and practiced for more than 40 years in the Guyandotte section of Huntington before his retirement.

He was an honorary life member of the Cabell County Medical Society, West Virginia State Medical Association and the American Medical Association.

Besides his widow, he is survived by two stepsons, Russell E. Webster and Elwood A. Webster, both of Huntington, and several nieces and nephews, including Drs. Charles O. Reynolds and Wilson P. Smith, both of Huntington.

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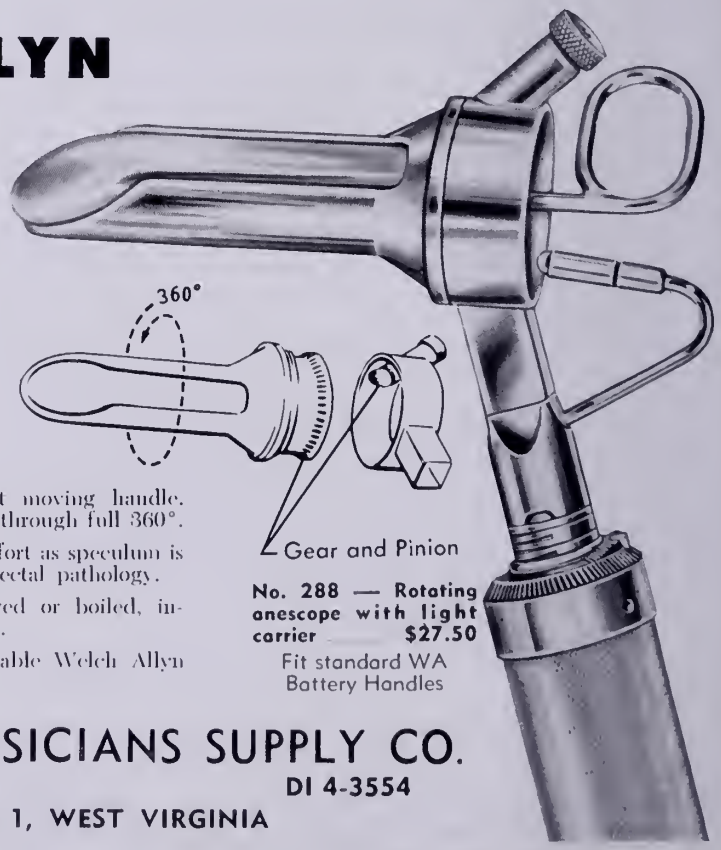

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CHARLES NICKELL WATTS, M. D.

Dr. Charles Nickell Watts, 91, of Charleston, died on June 19 at a hospital in that city after a long illness.

Doctor Watts was born December 19, 1872, in Covington, Virginia, and attended the University College of Medicine in Richmond, Virginia. He received his M. D. degree in 1900 from the University of the South Medical Department, Sewanee, Tennessee.

He took postgraduate work at the Medical College of Virginia, the University of Maryland School of Medicine and the Baltimore and Presbyterian Eye, Ear, Nose and Throat hospitals in Baltimore.

During the nationwide influenza epidemic of 1918, Doctor Watts volunteered his service to the government and established hospitals in Virginia and West Virginia. He received a special award for his service to the nation.

Doctor Watts practiced in Fairmont and the southern West Virginia coalfields before moving to Charleston in 1935, where he practiced until he was 85 years of age.

He was an honorary life member of the Kanawha Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by a son, Dr. Charles N. Watts, Jr., of Knoxville, Tennessee, and a daughter, Mrs. O. F. Cavendish, Jr., of Indianapolis, Indiana.

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KARL J. MYERS, M. D.

Pathology:
S. D. WU, M. D.

Surgery:
HU C. MYERS, M. D.
A. KYLE BUSH, M. D.

Gynecology and Obstetrics:
RAYMOND W. CRONLUND, M. D.

Internal Medicine:
JOHN E. LENOX, M. D.
J. L. RITTMEYER, M. D.
ERNEST G. GUY, M. D.

Pediatrics:
CORA C. LENOX, M. D.

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County Societies

BARBOUR-RANDOLPH-TUCKER

Dr. Ernest G. Guy of Philippi was elected president of the Barbour-Randolph-Tucker County Medical Society at its regular monthly meeting which was held at Blackwater Falls Lodge near Davis on May 21. He succeeds Dr. Vernon E. Duckwall of Elkins.

Other officers named for the coming year were as follows:

Dr. Homer D. Martin of Dailey, first vice president; Dr. S. M. Lilienfeld of Parsons, second vice president; Dr. Guy H. Michael, Jr., of Parsons, treasurer; Dr. A. Kyle Bush of Philippi, secretary; and Drs. Robert R. Rector of Elkins, J. R. Woodford of Philippi and S. M. Lilienfeld, members of the Board of Censors.

Dr. Richard A. Currie of Morgantown, Assistant Professor of Surgery at the West Virginia University School of Medicine, was the guest speaker.

Doctor Currie presented a paper on "Surgical Management of Carcinoma of the Lung." He discussed the types of lung tumor, stating that 56 per cent were the epidermoid type occurring in male smokers. He also discussed the reliability of diagnosis by x-ray. He said that cytologic examination of bronchial washings increased the protection of diagnosis about 10 to 15 per cent.

In relation to surgical management, Doctor Currie said that careful screening is needed to eliminate inoperable cases and that an aggressive attempt should be made at total excision of the lesion when it is operable.—A. Kyle Bush, M. D., Secretary.

* * * *

EASTERN PANHANDLE

The Eastern Panhandle Medical Society was host to the members of its Auxiliary and Martinsburg dentists and pharmacists and their wives at its regular monthly meeting which was held at the Shenandoah Hotel in Martinsburg on June 10.

The guest speakers were Martinsburg attorneys Robert M. Steptoe and Joseph F. Wagner, candidates for the West Virginia House of Delegates. Mr. Steptoe, who is seeking his second term, and Mr. Wagner discussed past and pending legislation.

* * * *

MARION

Dr. William T. Lawson was named president of the Marion County Medical Society during a meeting held in Fairmont in May. He succeeds Dr. James E. Wotring of Fairview.

Other officers named for the coming year are as follows:

Dr. Robert J. Sidow, vice president; Dr. G. Thomas Evans, secretary; Dr. John J. Coogle, treasurer; and Drs. J. J. Jenkins, Jr., David Bressler and Frederick G. Shaffer, members of the board.

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OFFICERS OF COMPONENT SOCIETIES

Society	President		Secretary		Meetings
Barbour-Randolph-Tucker	Ernest G Guy	Philippi	A. Kyle Bush	Philippi	3rd Thurs.
Boone	A. E. Glover	Madison	Harold H. Howell	Madison	2nd Wed.
Brooke	W T. Booher, Jr	Wellsburg	W. T. Booher, Sr.	Wellsburg	
Cabell	Clarence H. Boso	Huntington	W. L. Neal	Huntington	2nd Thurs.
Central West Virginia	Donald S. Groves	Summersville	R L. Chamberlain	Buckhannon	As Scheduled
Eastern Panhandle	F. A. Hamilton, Jr.	Martinsburg	E. Andrew Zepp	Martinsburg	2nd Wed
Fayette	Chuan H. Lee	Montgomery	D. Alene Blake	Oak Hill	1st Wed
Greenbrier Valley	Harvey A. Martin	White Sul. Spgs.	Stuart T. Bray	White Sul. Spgs.	2nd Wed
Hancock	David H Williams	Weirton	Ray S. Greco	Weirton	2nd Tues.
Harrison	Robert S. Wilson	Clarksburg	Richard K Hanifan	Clarksburg	1st Thurs.
Kanawha	George L Grubb	Charleston	Henry R. Glass, Jr.	Charleston	2nd Tues.
Logan	George R Mullins	Logan	Thomas P. Long	Man	2nd Wed
Marion	William T. Lawson	Fairmont	G. Thomas Evans	Fairmont	Last Tues.
Marshall	Kenneth J Allen	Moundsville	J. W. Myers	Moundsville	Semi-Ann.
Mason	C. Leonard Brown	Pt Pleasant	Richard L. Slack	Pt. Pleasant	Bi-Monthly
McDowell	John S. Cook	Welch	David J. Skewes	Coalwood	2nd Wed
Mercer	John J. Mahood	Bluefield	J. Brookins Taylor	Bluefield	3rd Mon.
Mingo	Andrew H. Henderson	Williamson	Russell A. Salton	Williamson	2nd Wed.
Monongalia	Reginald Krause	Morgantown	W. E. King	Morgantown	1st Tues.
Ohio	Joseph L. Curry	Wheeling	A J Purpura	Wheeling	4th Tues.
Parkersburg Academy	Robert C. Lincicome	Parkersburg	Dwight P. Cruikshank	Parkersburg	1st Thurs.
Potomac Valley	Robert W. Bess, Jr	Piedmont	William H. Boone	Keyser	2nd Wed.
Preston	W Parke Johnson Jr	Masontown	C. Y. Moser	Kingwood	4th Thurs.
Raleigh	B B. Richmond	Beckley	Richard G. Starr	Beckley	3rd Thurs.
Summers	J W Stokes	Hinton	D. W. Ritter	Hinton	3rd Mon.
Taylor	K H Trippett	Grafton	Paul P. Warden	Grafton	Last Thurs.
Wetzel	Lemoyne Coffield	N. Martinsville	Charles P. Watson	New Martinsville	Monthly
Wyoming	Jorge Piedra	Mullens	Ross E. Newman	Mullens	Quarterly

OFFICERS OF COUNTY AUXILIARIES

Society	President		Correspondent	
Boone	Mrs. H. H. Howell	Madison	Mrs. Wyson Curry, Jr.	Madison
Cabell	Mrs. M. Bruce Martin	Huntington	Mrs. C. L. Terlizzi	Huntington
Central West Virginia	Mrs. Edward H. Hunter	Richwood	Mrs. John E. Echols	Richwood
Eastern Panhandle	Mrs. L. Walter Fix	Martinsburg	Mrs. E. Walter Rice	Martinsburg
Fayette	Mrs. Ivan H. Bush, Jr.	Oak Hill	Mrs. J. B. Thompson	Oak Hill
Greenbrier Valley	Mrs. Philip W. Oden	Ronceverte	Mrs. Robert R. Pittman	Marlinton
Hancock	Mrs. Leonard E. Yurko	Weirton	Mrs. Eli Joel Weller	Weirton
Harrison	Mrs. Paul E. Gordon	Clarksburg	Mrs. Karl A. Dillinger	Clarksburg
Kanawha	Mrs. Earl A. McCowen	Charleston	Mrs. William A. Cracraft	Charleston
Logan	Mrs. David W. Mullins	Logan	Mrs. Erwin R. Chillag	Holden
Marion	Mrs. William A. Ehrgott	Fairmont	Mrs. Robert B. Hamilton	Fairmont
McDowell	Mrs. J. Hunter Smith	Welch	Mrs. John H. Murry	Gary
Mercer	Mrs. Joe E. McCary	Princeton	Mrs. L. J. Pace	Princeton
Mingo	Mrs. Robert J. Tchou	Williamson	Mrs. Frank J. Burian	Williamson
Monongalia	Mrs. Arthur W. Kelley	Morgantown	Mrs. John J. Lawless	Morgantown
Ohio	Mrs. C. B. Buffington	Wheeling	Mrs. W. Carroll Boggs	Wheeling
Potomac Valley	Mrs. Robert W. Bess, Jr.	Westernport, Md.	Mrs. Vernon L. Dyer	Petersburg
Preston	Mrs. William H. Horriman, Jr.	Terra Alta	Mrs. W. Parke Johnson, Jr.	Arthurdale
Raleigh	Mrs. Charles W. Merritt	Beckley	Mrs. Walter E. Klingensmith	Beckley
Taylor	Mrs. Herbert N. Shanes	Grafton	Mrs. Herbert N. Shanes	Grafton
Wood	Mrs. Charles W. Thacker	Vienna	Mrs. Robert W. Howes, Jr.	Parkersburg
Wyoming	Mrs. Byron W. Steele	Mullens	Mrs. George F. Fordham	Mullens

Woman's Auxiliary

to the

WEST VIRGINIA STATE MEDICAL ASSOCIATION

President: Mrs. Pat A. Tuckwiller, Charleston
President Elect: Mrs. George A. Curry, Morgantown
First Vice President: Mrs. Lysle T. Veach, Petersburg
Second Vice President: Mrs. Charles S. Harrison Clarksburg
Third Vice President: Mrs. Joe N. Jarrett, Oak Hill
Fourth Vice President: Mrs. Wilson P. Smith, Huntington
Treasurer: Mrs. Grover C. Hedrick, Jr., Beckley
Recording Secretary: Mrs. Robert J. Tchou, Williamson
Corresponding Secretary: Mrs. James T. Spencer, Charleston
Parliamentarian: Mrs. John W. Hash, Charleston

CABELL

Mrs. M. Bruce Martin was elected president of the Woman's Auxiliary to the Cabell County Medical Society at the regular monthly meeting which was held at the home of Dr. and Mrs. Gilbert A. Ratcliff on May 13. She succeeds Mrs. Frank M. Peck of Huntington.

Other new officers for the coming year are as follows:

Mrs. John R. Parsons, president elect; Mrs. D. Sheffer Clark, vice president; Mrs. Harold N. Kagan, secretary; and Mrs. Charles A. Hoffman, Jr., treasurer.

The new officers were installed by Mrs. Wilson P. Smith of Huntington, fourth vice president of the Woman's Auxiliary to the West Virginia State Medical Association.

* * * *

CENTRAL WEST VIRGINIA

Mr. William T. O'Farrell, attorney of Charleston, was the guest speaker at a joint dinner meeting of the Central West Virginia Medical Society and Auxiliary which was held at Gassaway on June 25. Attorneys and their wives from the area served by the Society also attended as guests.

Mr. O'Farrell emphasized the greater need for communication between the trial lawyer and the physician as a witness, especially through pre-trial conferences. He said the physician should come to court free of prejudice with the attorney arranging a convenient time for him to appear. He said there should be no need for an attorney to "badger" a physician who appears as a witness.

The business meeting of the Auxiliary was held at the home of Dr. and Mrs. Earl L. Fisher in Gassaway. Mrs. Edward H. Hunter of Richwood was elected president succeeding Mrs. Fisher. Other officers elected for the coming year are as follows:

Mrs. Donald S. Groves of Summersville, vice president; Mrs. John E. Echols of Richwood, secretary; and Mrs. Gerald J. Gelford of Webster Springs, treasurer.

Mrs. Fisher was commended for her annual report and Mrs. J. C. Huffman of Buckhannon, chairman of the Health Careers Committee of the Woman's Auxiliary to the State Medical Association, urged increased support in this field.—Mrs. John E. Echols, Secretary.

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Book Reviews

CIBA FOUNDATION STUDY GROUP NO. 16. The Immunologically Competent Cell: Its Nature and Origin—Edited by G. E. W. Wolstenholme, O. B. E., M. A., M. B., M. R. C. P., and Julie Knight, B. A. Pages 110 with illustrations. Little, Brown and Company, Boston, Massachusetts. 1963.

The current growth of the field of immunology has been largely due to the many important discoveries of both basic biological and medical interest in recent years. The practitioner recognizes the need for advanced knowledge in the areas of hypersensitivity, auto-immunization, thymic function, tumor immunity and transplantation immunity. An understanding of these phenomena rests with an elucidation of the seat of immunlogical reactivity—the immunologically competent all. The word "competent" in this context refers to the present status of a cell, which though capable of antibody production or initiation, is not yet necessarily thus engaged.

This volume contains a collection of six papers presented by such distinguished medical immunologists as Medawar, Gowans, White and Sorkin. In addition, each paper is followed by a lively discussion by the above authors and the well known scientists Brent and Billingham, as well as other distinguished participants.

The highly analytical technique of fluorescent antibody staining is discussed in its role in determining the nature of the cell types which are immunologically functional. Among those cells which are most often discussed as having immunological activity are plasma cells and small lymphocytes. The paper by Professor Gowans' group presents quite convincing data concerning the role of the lymphocyte in homograft rejection.

One of the newer concepts of immunology, the cytophilic antibody, is discussed by Professor Sorkin. These humoral substances are capable of becoming attached to cells in such a way that they are subsequently reactive with antigen. The idea that these antibodies are

New Saunders Books

W. B. Saunders Company features the following new books and new editions in their full page advertisement appearing on page iii in this issue:

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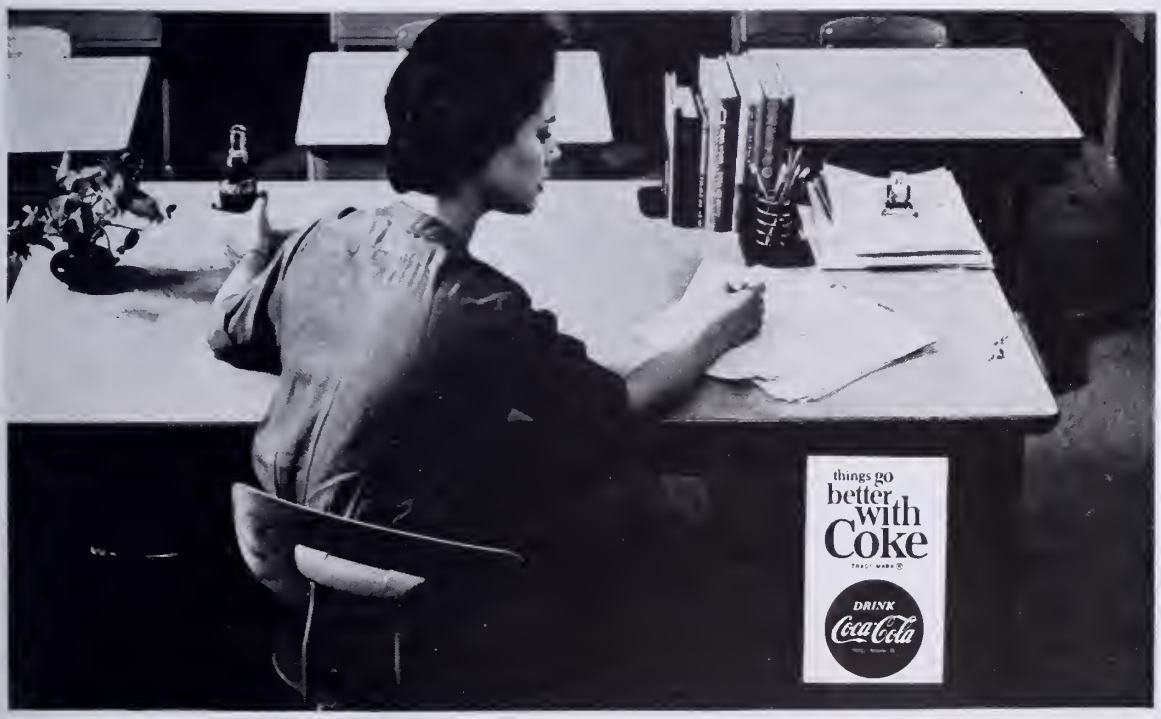

Whether you're a teacher correcting exams. A student cramming for them. A housewife cleaning up after the kids. Or a businessman working late at night. Whoever you are, things go better when you pause and refresh with ice-cold Coca-Cola.

responsible for delayed type hypersensitivity and homograft rejection is considered. The other papers relate to the basic research being applied to the origin of immunological competence in the thymus and the experimental work of Sir Macfarlane Burnet in regard to his popular theory of antibody production.

The book can be read by physicians interested in the foundations of the concepts of modern immunological thought. The extensive bibliography following each paper and the interesting general discussion following the whole session provided additional sources of information.—Robert G. Burrell, Ph.D.

THE PROSPECT OF IMMORTALITY—By Robert C. W. Ettinger. Pp. 190. 1964. Doubleday & Company, Inc., Garden City, New York. Price $3.95.

This is an intriguing, stimulating and provocative book. To summarize, the author's main idea is that when a person, dies, he or she should be frozen and preserved indefinitely. Mr. Ettinger is of the opinion that sooner or later medical science will be able to revive and treat the "dead" person and they can live on again, possibly forever.

The idea at first glance may appear naive, but is it really? Many scholarly and renowned scientists, including the writer of the preface, the famous Dr. Jean Rostand, are of the opinion that eventually "immortality" is possible. The intriguing aspects about the idea are the philosophical, theological, and social questions raised. Mr. Ettinger brings up many of these questions but, of course, does not imply that he or anyone at this point knows all the answers.

Mr. Ettinger writes well. He is not a fanatic. He writes seriously, but mixes in a good bit of humor without depreciating the ideas presented.

The book is recommended, if for no other reason than to bring up the author's contentions to friends and get their reaction. The reviewer has done this—some persons are offended, they think it is almost blasphemous—some persons are insulted, they think it is depreciating to their scientific wit—most persons are "agin" it, they just don't care to live forever—at least in this world.—David H. Smith, M. D.

* * * *

COMMON COMPLAINTS—A Collection of Medical Articles by Eugene W. Jackson, Consultant Staff. Pp. 206. Smith Kline & French Laboratories. 1964. Pennsylvania. Price $3.00.

This little book is a collection of medical articles from the monthly trade journal, *Consultant.*

There are 40 contributors who are all outstanding teachers of medicine. The articles in the book represent the commonest or the most interesting of medical complaints.

The book reads well and easily. The material is well arranged and the authors frequently are opinionated. The subjects under discussion constitute a large portion of ordinary office complaints. The section called "Nuisance Complaints"—snoring—fatigue—colic—low blood pressure, etc., are delightful reading and give the

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reader some criteria whereby he may assess the constitutional etiology of these complaints.

Those physicians accustomed to ordering TAT for every abrasion should read Doctor Metzger's chapter on office treatment of cuts.

The section on skin diseases will be helpful to any physician who finds himself reluctantly forced to treat some simple skin ailments.

The book is interesting reading and will be helpful in office practice. The pharmaceutical company does not intrude its medicaments into the recommendations of the consultants.

* * * *

MEDICAL PHARMACOLOGY—By Andres Goth, Ph.D., Professor of Pharmacology and Chairman of the Department, The University of Texas Southwestern Medical School, Dallas. Pp. 585, The C. V. Mosby Company, 3207 Washington Blvd., St. Louis 3, Missouri. 1964. Price $11.75.

The second edition of this textbook has the same organization as its predecessor and is only slightly larger despite the inclusion of discussions of many of the newer drugs, such as the newer antihypertensive agents, diuretics, penicillins and many more. Doctor Goth places great emphasis on the presentation of current concepts of pharmacology since these form the basis upon which the physician must rely in his evaluation of the never ending stream of new drugs.

Among the newer concepts included in this edition are those on the mode of action of sympathomimetic drugs, metabolism and release of catecholamines, beta adrenergic blocking agents and the treatment of drug addiction.

Instead of listing therapeutic uses at the end of many chapters, Doctor Goth makes concise statements on current status under the heading of clinical pharmacology.

The book is well organized, concise and readable. It is designed not only for classroom use, but also for the physician who wants to keep up in this rapidly changing field.—Robert L. Robinson, Ph. D.

* * * *

CIBA FOUNDATION SYMPOSIUM—DISORDERS OF LANGUAGE—By A. V. S. DeReuck, M. Sc., D. I. C., A. R. C. S. and Maeve O'Conor, B. A., Little, Brown and Company. Boston, 1964. Pp. 356 with 35 illustrations. Price $11.00.

This symposium has truly an international and interdisciplinary flavor. It was composed of expert neurologists, psychologists, phoneticians, linguists, philosophers, and one information theorist, coming from America, England and Europe. Their wide backgrounds and various fields of training provided a broad scope for viewing the field of language problems. This diversity, however, also created some problems in grasping fully the extensive coverage of the papers. One can at best be qualified in only one of the fields that were involved in the symposium. Some of the formal and technical material presented from viewpoints other than the reader's background can be difficult to grasp on the first reading.

As the fields of training involved in the symposium varied, so did the methodology used to collect the data. Procedures varied along a continuum from very formal and strict scientific methodology involving operational definitions through observations of clinical patients to the philosophical speculations that attempted to clarify problems and to organize concepts into sensible propositions. The main point of study was aphasia, but some papers were presented that studied the normal speech process. These were considered as baseline patterns for studying speech variations in language problems.

The first part of the book contained more of the technical and formal experimental material. This would probably be of more interest to the academic person than to the practicing clinician. It had a strong basis in theory, and much of it was related to testing hypotheses derived from portions of the theories. The first part of the book was more difficult reading due to its highly specialized nature. The last part of the book was related more to clinical problems and investigation. It dealt with data collected from clinical observations and with some of the issues of definition and theory related to language problems. A very enjoyable part of the book was the discussion of the papers by the entire group after each presentation. This offered the insights and related material that each of the experts had at his disposal, and it made the writer almost feel that he had attended the symposium.

For those people not interested in studying the entire area of language problems as presented in this symposium, they may find this book useful as a reference for specific problems of interest. Each paper has a bibliography that provides a good starting point for intensive study of any one area of interest. With such a gathering of distinguished people, it is difficult to imagine that this book would not be useful in some way to anyone interested in language problems.—Robert B. Duke, Ph. D.

YOU CAN RAISE YOUR HANDICAPPED CHILD—By Evelyn West Ayrault. Putnam Press, New York City.

Miss Ayrault has written an interesting, non-technical volume which will be of great usefulness to parents of handicapped children.

Her practical manner of approaching the problem of giving love, support, discipline, guidance and training is so logical that one wonders why it is not universally used. It also is unclear how supposedly sophisticated workshop personnel can be so blinded by obvious disability that little concern is directed toward the emotional impact of the handicap on the patient or the parents.

The directory of agencies, state by state, available to the parents should be of considerable help.

This book is recommended reading for parents of handicapped children, but also for all those who work with these unfortunate children in any capacity. It would prove beneficial also for rehabilitation counselors (so that they may know that the parents have a checklist, so to speak), doctors (pediatricians, family physicians, internists and psychiatrists), psychologists, and workshop directors and staff personnel.—Ralph H. Nestmann, M. D.

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1964

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Official Organ of the West Virginia State Medical Association

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CONTENTS

Scientific Articles

An Evaluation of the Glucose Skin Test in the Diagnosis of Diabetes Mellitus—Frank E. Medford, M. D. 255

Pre-Commencement Exercises: West Virginia University School of Medicine—Hon. Okey L. Patteson 258

Medicine in Retrospect—Norman A. Welch, M. D. 262

The President's Page

The Year Ahead—Albert C. Esposito, M. D., President, West Virginia State Medical Association 266

Editorials

Reminiscing and Old Age 267

The Cost of Medical Care 268

General News

Rural Health Conference 269

W. Va. Heart Assn. Meeting 270

PG Course on Tuberculosis 272

Medical Aspects of Sports 274

Diabetes Assn. Meeting 275

Special Departments

WVU Medical Center xxiv

The Month in Washington xxvi

Obituaries xxviii

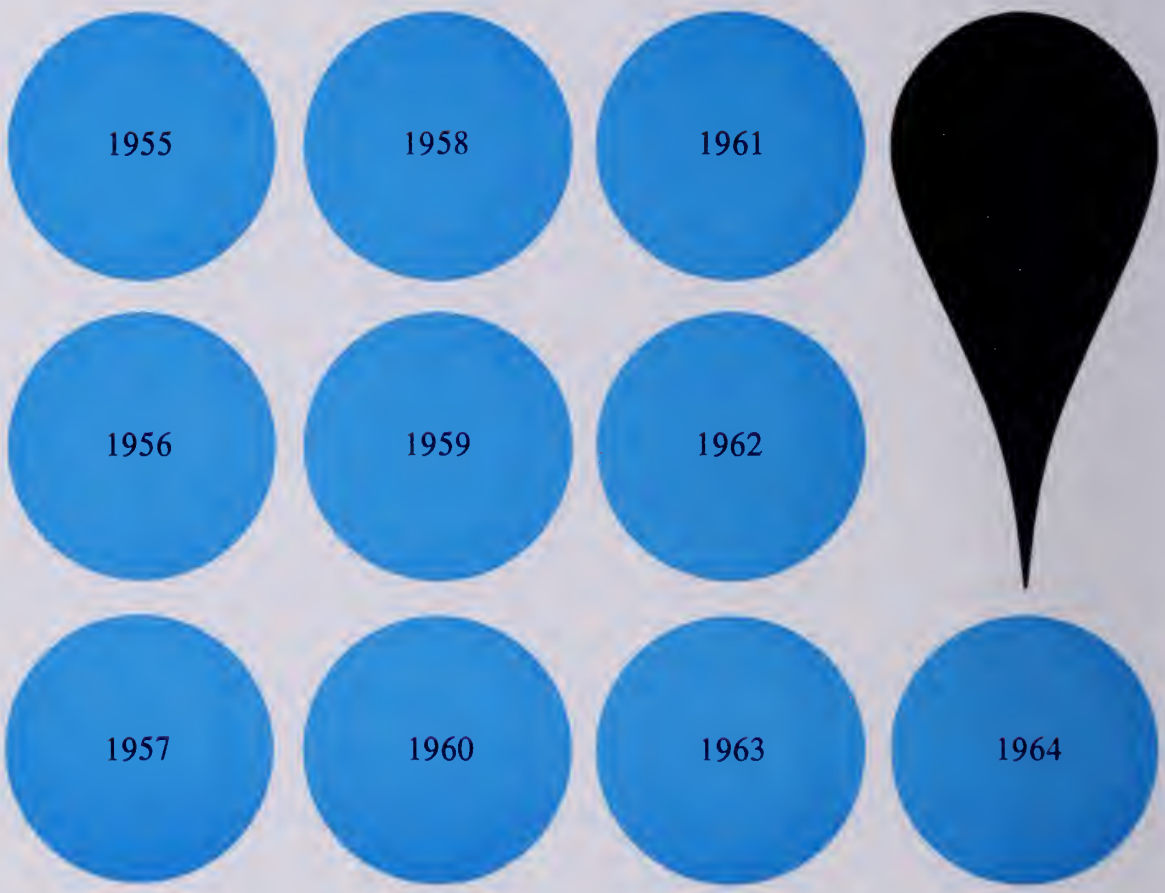
County Societies xxx

Book Reviews xxxii

Directory of Physicians in Limited Practice xxxvii

Index to Advertisers xl

The clear conclusion from 10 years' experience...



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1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

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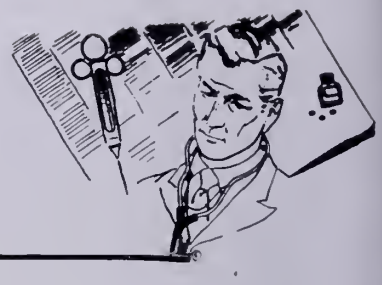
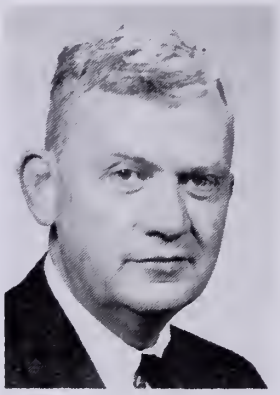


Dr. Edward G. Stuart, Assistant Dean of the West Virginia University School of Medicine, has been named director of the new Institute of Biological Sciences at the University.



Edward G. Stuart, M. D.

The Institute of Biological Sciences was established in April following recommendations of the University Planning Committee and a special inter-college study committee.

Doctor Stuart joined the WVU faculty in 1960 from the University of Virginia School of Medicine. He was named Assistant Professor of Pathology and in 1961 was appointed assistant to Dean Clark K. Sleeth and elevated to the rank of Associate Professor of Pathology.

He was graduated from West Chester State Teachers College in West Chester, Pennsylvania, and received graduate degrees in zoology and anatomy from Temple University and the University of Pennsylvania.

He received his M.D. degree in 1955 from the Duke University School of Medicine. He served an internship at the Chester County Hospital in West Chester, Pennsylvania, 1956-57, and was named Instructor in Pathology at the University of Virginia School of Medicine in 1957.

Seven New Faculty Members

The appointment of seven new members of the WVU School of Medicine faculty has been announced by Dean Clark K. Sleeth.

Dr. Ruth M. Phillips, a native of Johannesburg, South Africa, was named Assistant Professor of Pediatrics. She formerly served as Clinical Assistant Professor. Doctor Phillips was graduated from Mt. Holyoke College and received her M.D. degree from the Johns Hopkins University School of Medicine. She is married to Dr. Robert R. Trotter, Associate Professor of Surgery and Chairman of Ophthalmology at the WVU School of Medicine.

Drs. Thomas E. Gretter, Thomas J. Tarnay, John H. Wolf, Jr., Raj K. Gupta and David H. Smith were named instructors in neurosurgery, surgery, pediatrics, pathology and psychiatry, respectively.

• **Compiled from material furnished by Howard Lewis, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

Doctor Gretter is a native of Fargo, North Dakota, and was graduated from the University of North Dakota. He received his M. D. degree from the University of Pennsylvania School of Medicine and served an internship at the Milwaukee County Hospital in Milwaukee, Wisconsin. He recently completed a three-year residency in neurology at the State University of Iowa College of Medicine.

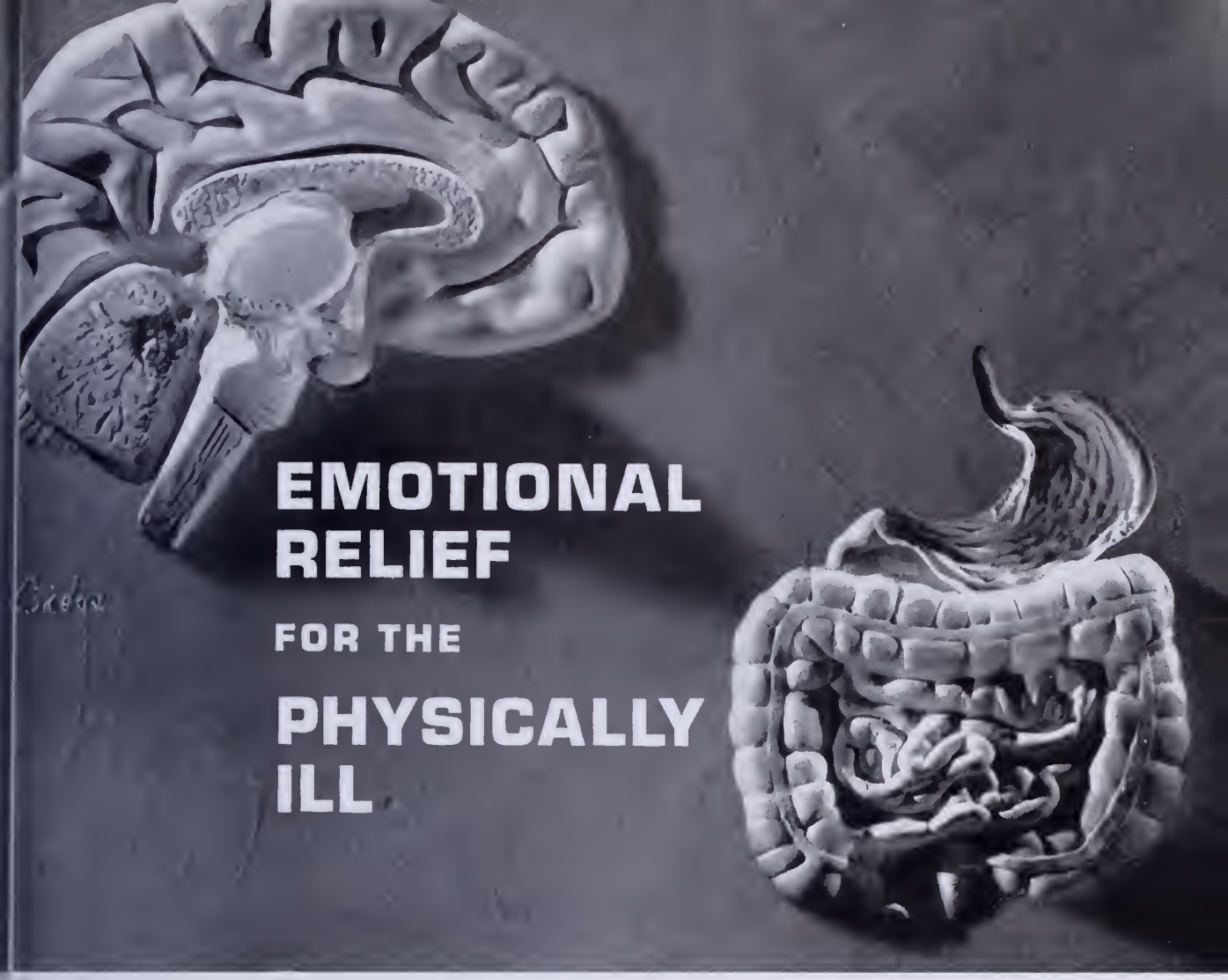
Doctor Tarnay is a native of New York City and was graduated from Cornell University. He received his M. D. degree from the Columbia University College of Physicians and Surgeons and served an internship at the Bellevue Hospital in New York City. He served a residency in surgery at the WVU Hospital and was Chief Surgical Resident, 1963-64.

Doctor Wolf, who will serve as a Clinical Instructor, is a native of Grafton and was graduated from WVU. He received his M. D. degree from the Bowman-Gray School of Medicine in Winston-Salem, North Carolina, and recently completed a residency in pediatrics at the WVU hospital. He is now in private practice in Morgantown.

Doctor Gupta is a native of Kasaganj, India, and he received his M. D. degree from the Medical College of Agra University, Gwalior, India. He taught pathology at that university and in New Delhi, India, and previously served as chief resident in anatomic pathology at Memorial Hospital in Worcester, Massachusetts.

Doctor Smith, a practicing psychiatrist in Wheeling, will serve as a Clinical Instructor in Psychiatry. He is a native of Frank, Alberta, Canada, and he received his M. D. degree from the University of Alberta Faculty of Medicine. He served an internship at Edmonton General Hospital in Alberta and a residency in psychiatry at Utica State Hospital in Utica, New York. He formerly served as clinical director and assistant superintendent at Clark Summit State Hospital in Scranton, Pennsylvania.

Raymond E. Vanderlinde, Ph.D., accepted an appointment as Clinical Assistant Professor of Pathology. He was graduated from Syracuse University and he received two M. S. degrees, one in science education and the other in organic chemistry; and a Ph.D. in medical biochemistry from the same university. He now serves as associate director and clinical chemist at Memorial Hospital in Cumberland, Maryland.



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The Month in Washington

• From the Washington Office of the American Medical Association.

CONGRESS for the first time has authorized funds for modernization and renovation of hospitals. The modernization and renovation program was included in legislation that extends the Hill-Burton hospital construction program for five more years. The legislation easily won approval in both the House and Senate.

The extension provides $840 million for construction of hospitals and public health centers and for the modernization of health facilities.

Of that amount, $680 million is designated for construction and $160 million for modernization with a provision that up to $350 million of the construction funds can be switched to modernization if a state deems it preferable.

The new law also provides:

$350 million for construction of long-term facilities, including nursing homes and chronic disease hospitals.

$100 million for construction of diagnostic or treatment centers.

$50 million for construction of rehabilitation facilities.

$7.5 million in matching grants for areawide health facility planning in metropolitan and other areas. Under this project, states can use up to two per cent of their allotment to improve state administration of the construction program.

Change in Labeling Ordered

The Food and Drug Administration has ordered that drugs containing phenacetin (acetophenetidin) be relabeled to bear a warning against kidney damage. The order becomes effective Oct. 6, 1964.

The new labeling follows:

"Warning—This medication may damage the kidneys when used in large amounts or for a long period of time. Do not take more than the recommended dosage, nor take regularly for longer than 10 days without consulting your physician."

The labeling change was based on a report by a special advisory committee which concluded after a study of the pain-relieving drug that there is probable cause to conclude that misuse and prolonged use of the drug have been responsible for kidney lesions and disease.

The FDA also has banned and seized a number of "sustained action" or "time disintegration" cold capsules on charges of false claims. The agency said that the products are manufactured by only a few firms for distribution under more than 100 private brand names.

The over-the-counter products are generally labelled as providing up to 12 hours of continuous relief of excessive nasal discharge, running nose, watering of the eyes, swelling of the nasal tissues and stuffy congested feeling caused by the common cold and hay fever, the FDA said.

Dr. Joseph F. Sadusk, Jr., FDA Medical Director, said the seized products contain too little of active ingredients to be effective over a 12-hour period. Should a capsule contain an effective dose for a 12-hour period, he said, "a new drug" approval would be required to assure safety and efficacy.

Influenza Vaccines

The Public Health Service has approved the strengthening of influenza vaccines and is again urging that the so-called "high-risk" groups be inoculated against the respiratory disease—between Sept. 1 and Dec. 15 this year.

The PHS acted upon the recommendations of the special committee on immunization practices which reported that flu vaccines had been shown "in repeated control trials to confer a substantial protection (60 to 80 per cent)."

The incorporation of recent A_2 and B isolates in the 1963-64 vaccine and the increase in their concentration during 1964-65 should result in a vaccine capable of conferring substantial protection in 1964-65, the committee said. It was pointed out, however, that as yet there has been no opportunity to evaluate the newly constituted vaccine under conditions of a natural challenge.

The committee forsaw no major influenza outbreak in the United States this year but recommended inoculation since there is always a possibility of local outbreaks.

The committee recommended that immunization should be considered and generally recommended for persons in groups who experience high mortality from epidemic influenza.

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Vitamin B_{12} Crystalline	4 mcgm.
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Obituaries

CREED COLLINS GREER, M. D.

Dr. Creed Collins Greer, 63, of Clarksburg, died on July 16 at a hospital in that city.

He was born on May 3, 1901, at Pennsboro, the son of the late William Homer and Marion Collins Greer. He attended the two-year School of Medicine at West Virginia University and received his M. D. degree in 1928 from the University of Maryland School of Medicine.

Doctor Greer served an internship at the American Hospital in Baltimore, 1928, and a residency at the Fairmont General Hospital in 1929.

He was an honorary life member of the Harrison County Medical Society, West Virginia State Medical Association and American Medical Association.

He is survived by two sons, Creed Collins Greer, Jr., of Springhill, Louisiana, and William W. Greer of Philadelphia; and one daughter, Mrs. Earl Hawley of Las Vegas, Nevada.

GORDON LIVINGSTON TODD, JR., M. D.

Dr. Gordon Livingston Todd, Jr., 50, of Princeton, died on July 23 at a Bluefield hospital after a brief illness.

He was born in Princeton, April 21, 1914, the son of the late Dr. Gordon L. and Lena Rixey Todd. He attended public schools in Princeton and the University of Virginia. He received his M. D. degree in 1940 from the University of Virginia School of Medicine.

Doctor Todd served an internship at Memorial Hospital in Bethlehem, Pennsylvania, 1940, before entering the Medical Corps of the United States Army in 1941.

During World War II he served on the staffs of various Army hospitals in the United States before being transferred to the European Theater of Operations. He was released from active duty in 1945 with the rank of Captain and returned to Princeton where he joined the staff of Memorial Hospital, assisting his father.

After the death of his father in 1948, Doctor Todd served a residency in surgery at Cincinnati General Hospital, 1948-54.

Doctor Todd was a member of the Mercer County Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by two sons, Gordon L. Todd, III, a student at Kenyon College in Gambier, Ohio, and Rixey Browning Todd of Princeton.

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First National Congress on Strokes Planned in Chicago, Oct. 29-31

The First National Congress on Strokes, designed to stimulate a wide-spectrum program of prevention and management of strokes and rehabilitation of stroke patients, has been scheduled for the Palmer House in Chicago, October 29-31.

Sponsoring agencies are the American Medical Association, American Heart Association, Heart Disease Control Program of the U.S. Public Health Service, and Vocational Rehabilitation Administration of the Department of Health, Education and Welfare.

In announcing the Congress, the chairman, Dr. Frank H. Krusen of Temple University School of Medicine, Philadelphia, pointed out that the once hopeless connotation of the word "stroke" can be modified by newly developed concepts and techniques in prevention, and by practices developed in the last two decades in rehabilitation.

Doctor Krusen said the high prevalence of strokes, third leading cause of death in the United States, is amenable to attack. But to be effective, all members of the community of health services must be willing to participate.

Physicians, nurses, therapists of all disciplines, administrators, social workers, psychologists, vocational counselors, community planners and legislators, all have great responsibility in translating the vision of new attitudes and practices into action on a large scale, he added.

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County Societies

CABELL

The annual picnic of the Cabell County Medical Society was held at Dr. Richard J. Stevens' Dixielou Farm near Huntington on July 9.

Dr. Clarence H. Boso, the president, presided at the business meeting and Drs. J. Samuel Griffith and William S. Sheils were unanimously elected to membership in the Society.—W. L. Neal, M. D., Secretary.

* * * *

MONONGALIA

The regular monthly meeting of the Monongalia County Medical Society was held in Morgantown on June 2.

Dr. Nicholas W. Fugo, Professor and Chairman of Obstetrics and Gynecology at the West Virginia University School of Medicine, was the guest speaker.

Doctor Fugo presented a paper on "Menopause." His presentation was augmented by the utilization of slides. A question and answer session followed.

Drs. William E. King, French R. Miller, Robert J. Fleming and D. Franklin Milam were named delegates to the annual meeting of the State Medical Association at The Greenbrier, August 20-22. Their alternates are Drs. C. A. Logue, Maynard P. Pride, C. Truman Thompson and George A. Curry.—William E. King, M. D., Secretary.

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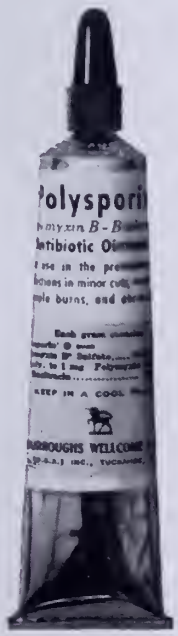

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PHYSICAL EXAMINATION OF THE SURGICAL PATIENT—By J. Englebert Dunphy, M. D., F. A. C. S., and Thomas W. Botsford, M. D., F. A. C. S.; W. B. Saunders Company; Philadelphia. Pp. 396. Illustrated. 1964. Price $8.50.

In this book the authors have taken well-known fundamental principles and procedures of the physical examination, and have presented them in a clear, concise modern form. They have correlated the finest from the diagnostic art of the "older masters" with the latest scientific medical knowledge, including laboratory aids and instrumental diagnostic aids that encompass "examination," and the resulting text is a joy for any physician to read, who has a nostalgic fondness for the art and science of medicine.

Far from being hidden behind a battery of laboratory tests and x-rays, the doctor's basic tools, "his eyes, ears, fingers, nose and brain" are shown forth in true perspective by the authors. It is a pleasure to watch the skillful and merciful surgeon examining the abdomen of an acutely ill patient, and this book attempts to reduce to writing the skill, knowledge, judgment, tenderness and dedication that we strive to bring to the patient's bedside.

In this third edition, the book is brought up to date, including the addition of new important chapters on cardiac surgery, burns, emergency resuscitation and the cancer examination. These supplement the fine chapters of earlier editions on the elective and the emergency examinations.

To the student, the clinician who does "routine" examinations, and especially to the surgeon, who often must make grave decisions on the basis of physical findings, this book comes as a refreshing review of the old as well as an authoritative evaluation of the newest in the techniques of the surgical examination.

Rx for the doctor: An annual check-up on his techniques of surgical examination.—Josiah Thompson, M. D.

Books Received

FUNDAMENTALS OF OTOLARYNGOLOGY—By Lawrence R. Boies, M. A., M. D., Professor of Otolaryngology, Chairman, Department of Otolaryngology, University of Minnesota Medical School; Jerome A. Hilger, M. D., M. S., Clinical Professor of Otolaryngology, University of Minnesota Medical School; and Robert E. Priest, M. D., M. S., Clinical Professor of Otolaryngology, University of Minnesota Medical School. Pp. 553 with illustrations. W. B. Saunders Company: Philadelphia and London. 1964, Fourth Edition. Price $8.50.

* * * *

SURGERY—World War II: Activities of Surgical Consultants—Prepared and published under the direction of Lt. General Leonard D. Heaton, the Surgeon General, United States Army. Editor in Chief: Col. John Boyd Coates, Jr., M. C., United States Army. Pp. 1100. 1964. Office of the Surgeon General, Department of the Army, Washington, D. C.

* * * *

THE LUNG AND ITS DISORDERS IN THE NEWBORN INFANT—By Mary Ellen Avery, A. B., M. D.; Alexander Schaffer, Consulting Editor. W. B. Saunders Company, Philadelphia. 1964. Pp. 224, with illustrations. Price $7.50.

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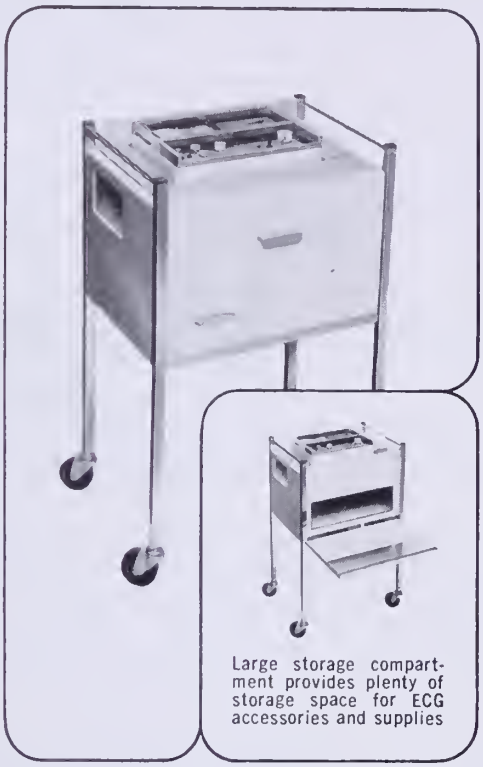

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CONTENTS

Scientific Articles

Medical Progress, Its Problems and Challenge—Charles L. Goodhand, M. D. 277
Chronic Bronchitis—Leslie N. Gay, M. D. 282
Safeguarding the Health of the Athlete—Kenneth S. Clarke, Ph. D. 286

The President's Page

Mountaineers Are Always Free—Albert C. Esposito, M. D., President, West Virginia State Medical Association 292

Editorials

The New President 293
Medical School Applications During the Last Decade 294
Nursing Program at Morris Harvey 295

General News

New Association Officers Installed 296
Resume of the Convention Proceedings 297
Pre-Convention Council Meeting 299
Amendments to By-Laws Adopted 301
Standing and Special Committees 304
Postgraduate Institute 308
The Auxiliary's Convention Story 310

Special Departments

WVU Medical Center 316
The Month in Washington 318
Annual Reports 320
Resolutions 323
Correspondence xxviii
Book Reviews xxxi
Directory of Physicians in Limited Practice xxxv
Index to Advertisers xxxviii

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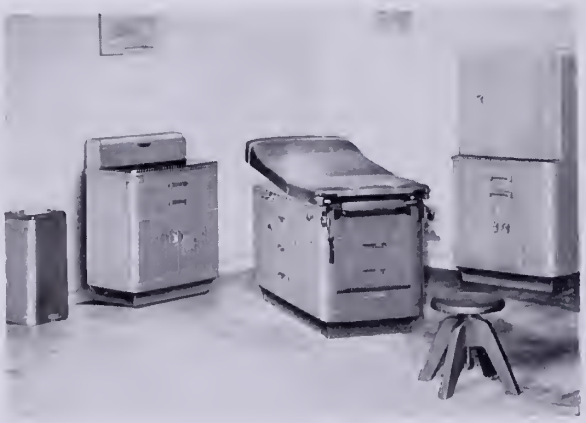

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Book Reviews

MARRIAGE COUNSELING IN MEDICAL PRACTICE — A Symposium Edited by Ethel M. Nash, M. A., Lucie Jessner, M. D., and D. Wilfred Abse, M. D. Pp. 368. The University of North Carolina Press, Chapel Hill. 1964. Price $8.

This book represents an attempt to enlarge the physician's awareness of the problems that arise in marriage. They are many and they are complex. They are presented to the doctor, whether a specialist or a general practitioner, every day—sometimes in the form of a physical symptom or organic disease, sometimes as an emotional symptom or mental illness, and sometimes, although less frequent, as a direct problem. Needless to say, if the basic problem is marital conflict masquerading as a medical disorder, medical or surgical treatment is not likely to succeed.

For the doctor interested in marital problems and their resolutions, this book will provide an excellent background to further study and reading. It does not have ready-made answers. It is not a panacea. It contains some articles that are too abstruse for other than the specialist, but by and large, it has a lot of information stated in terms that are understandable to any intelligent person.—David H. Smith, M. D.

GASTROENTEROLOGY: VOLUME II—By Henry L. Bockus, M. D. Illustrated, 1241 pp. W. B. Saunders Company, 1964. Price $28.00.

Volume II of Gastroenterology concerns the small intestine, colon peritoneum-mesentery and omentum. It is written by 36 authors. There are four sections, 46 chapters and more than 1200 pages in this volume. This edition is a complete rewriting and is not an ordinary revision.

Many of the authors are the same writers who edited the old text, but completely new sections have been added such as Section J, entitled, "Diseases of Absorption and Nutrition and Anemias," comprising over 150 pages. The volume is about 250 pages larger than the first edition. The pages are divided into two sections and print is slightly larger and more readable. Illustrations are well reproduced and are plentiful.

As in Volume I and previous editions a substantial section of this volume is devoted to anatomy and physiology.

The vague and little known conditions of the small intestine become more interesting in this volume.

The book needs no recommendation. Like the first edition it will be a classic reference for all conditions of the small intestine and colon.

The section on the colon is concerned with anatomy, physiology, anomalies and diagnostic studies. The chapters on roentgenology and sigmoidoscopy will be interesting and authoritative to many specialty fields. Every known eventuality seems to be well covered.

This book will be well received by all practitioners who have an interest in the field of gastroenterology.—George F. Evans, M. D.

New Saunders Books

W. B. Saunders Company features the following new editions in their full page advertisement appearing on page iii in this issue:

Doctor's Easaccount Record System—A financial record keeping system tailored specifically to the requirements of physicians.

Hughes—"Pediatric Procedures." Step-by-step instructions on scores of management procedures for child patients.

Bates and Christie—"Respiratory Function in Disease." A valuable aid in managing those patients suffering from lung conditions.

Books Received

MASSAGE—Principles and Techniques—By Gertrude Beard, R. N., R. P. T., Formerly Associate in Physical Medicine and Technical Director, Course in Physical Therapy, Northwestern University Medical School; Elizabeth C. Wood, A. M., M. S., R.P.T., Associate Professor of Physical Medicine and Educacational Administrator, Programs in Physical Therapy, Northwestern University School of Medicine. W. B. Saunders Company, Philadelphia. Pp. 163. Illustrated. 1964. Price $6.00.

* * * *

DISEASES OF METABOLISM—Detailed Methods of Diagnosis and Treatment—By Garfield G. Duncan, M. D., Professor of Medicine, University of Pennsylvania; Director of Medical Divisions, Pennsylvania Hospital and The Benjamin Franklin Clinic. Pp. 1551. Illustrated. W. B. Saunders Company, Philadelphia. 1964. Price $28.00

* * * *

PROCEEDINGS—The World Forum on Syphilis and Other Treponematosis—By U. S. Department of Health, Education and Welfare. United States Government Printing Office, Washington, D. C. Pp. 520. 1964.

* * * *

X-RAY TECHNOLOGY—By Charles A. Jacobi, B. Sc. (A.R.R.T), Assistant Professor, Medical X-Ray Technology and Radiation Health and Safety Officer, Radioactive By-product Installations, Oregon Technical Institute, Klamath Falls, Oregon; and Don Q. Paris, R. T. (A.R.R.T.) Chairman, Medical X-Ray Technology, Oregon Technical Institute. The C. V. Mosby Company, St. Louis. 1964. 306 Figues. Price $11.50.

* * * *

GIVE AND TAKE—The Development of Tissue Transplantation—By Francis D. Moore, M. D., Moseley Professor of Surgery, Harvard Medical School, Surgeon in Chief, Peter Bent Brigham Hospital, Boston, Massachusetts. W. B. Saunders Company, Philadelphia. 1964. Pp. 182. Illustrated. Price $5.50.

* * * *

CARDIAC ARREST AND RESUSCITATION—By Hugh E. Stephenson, Jr., B. S., M. D., F. A. C. S. Professor of Surgery, University of Missouri School of Medicine, Columbia, Mo. The C. V. Mosby Company, St. Louis. 1964. Pp. 410. Illustrated. Price $15.00.

* * * *

THE LIVER AND PORTAL HYPERTENSION—By Charles G. Child, III, M. D., Professor and Chairman, Department of Surgery, University of Michigan. Pp. 231. Illustrated. W. B. Saunders Company, Philadelphia. 1964. Price $8.50.

* * * *

CHRISTOPHER'S TEXTBOOK OF SURGERY—Edited by Loyal Davis, M. D., Professor of Surgery, Northwestern University Medical School. Pp. 1481 with illustrations. W. B. Saunders Company, Philadelphia. 1964. Price $18.50.

* * * *

DIET AND BODILY CONSTITUTION—By Ciba Foundation Study Group No. 17; Edited by: G. E. W. Wolstenholme, O. B. E., M. A., M. B., M. R. C. P. and Maeve O'Connor, B. A. Illustrated. Little, Brown and Company, Boston. 1964. Price $2.95.

* * * *

BUSINESS MANAGEMENT OF A MEDICAL PRACTICE—By Bernard D. Hirsh, LL. B., Director, Law Department, American Medical Association. Pp. 190. C. V. Mosby Company, St. Louis. 1964. Price $7.75.

* * * *

BETTER HEALTH FOR WOMEN—Charles Richard Alsop Gilbert, M. D. Illustrated. Doubleday & Company, Inc., New York. 1964. Pp. 365. Price $4.95.

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CONTENTS

Scientific Articles

A Special Report by The Kanawha Medical Society's Welfare Evaluation Committee 325

Air Pollution, Respiratory Disease and the NTA—Robert J. Anderson, M. D. 332

Postoperative Leukocytosis—Robert L. Bradley, M. D. 338

Special Article

Circadian Rhythm and Medicine—Edward J. Van Liere, M. D. 340

The President's Page

The Election and Thanksgiving—Albert C. Esposito, M. D., President, West Virginia State Medical Association 342

Editorials

Tuberculin Test is a Good Test 343
Carbon Monoxide Poisoning 344
What is an Extern? 345

General News

Proceedings of Rural Health Conference 346
AMA Clinical Meeting in Miami Beach 348
New Cancer Society Officers 349
Southern Medical Meeting in Memphis 350

Special Departments

WVU Medical Center News xxiv
The Month in Washington xxvi
Obituaries xxix
County Societies xxxii
Woman's Auxiliary xxxiii
Directory of Physicians in Limited Practice xxxvii
Index to Advertisers xl

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Research in the Service of Medicine

1. Roach, T. C.: Therapy of Peptic Ulcer, J. Louisiana Med. Soc. *115*:136-139 (April) 1963.
2. Steinberg, H., and Almy, T. P., Drugs for Gastrointestinal Disturbances, Chapter 21, in Modell, W. (editor): Drugs of Choice —1964-1965, St. Louis, The C. V. Mosby Company, 1964, p. 343.

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WVU Medical Center
–News–

Dr. Byron M. Bloor, Professor and Chairman of the Division of Neurosurgery at the West Virginia University School of Medicine, was recently elected a member of The Halsted Society. The Society, which has an active membership of 75, held its annual meeting at the WVU Medical Center, September 17-19.

Byron M. Bloor, M. D.

Three other members of the WVU faculty are members of the Society. They are Drs. Bernard Zimmermann, Professor and Chairman of Surgery; and Herbert E. Warden and Walter H. Gerwig, Jr., Professors of Surgery.

Doctor Bloor, a native of Idaho, received his M. D. degree from the Duke University School of Medicine. Before joining the WVU faculty in 1960, he was Assistant Professor of Neurosurgery at the Western Reserve University School of Medicine and Chief of the Neurosurgical Service at Cleveland City Hospital in Cleveland, Ohio.

He is the author of nearly two dozen papers which have appeared in professional journals and is a Diplomate of the Ameriean Board of Neurological Surgery.

Papers Presented by WVU Faculty

Doctors Bloor, Warden and Gerwig presented papers during the three-day meeting of the Society which is made up of internationally-known surgeons and physician specialists.

Other WVU staff members who presented papers on the anti-diuretic hormone, anesthesia, heart problems, kidney transplants, tumor spread, chest injuries, arteries, urinary tract disease, and brain injury, included:

Dr. Walter H. Moran, Jr., Assistant Professor of Surgery; Frederick W. Miltenberger, Surgery Resident; Wihbi A. Shu'ayb, Surgery Resident; Norman W. B. Craythorne, Associate Professor and Chairman of Anesthesiology; Kenneth E. Thomas and Eugene S. LaPlante, Surgery Residents; Alvin L. Watne, Associate Professor of Surgery.

Keith L. Stackhouse, Surgery Resident; Thomas J. Tarnay, Chief Surgery Resident; George R. Nugent, Assistant Professor of Surgery; Alfred D. Ghaphery, Surgery Resident; and D. Franklin Milam, Professor of Surgery and Chairman of the Division of Urology.

• **Compiled from material furnished by Arthur V. Ciervo, Director, Medical Center News and Information Services, Morgantown, West Virginio.**

Three Surgeons Contribute to Textbooks

Three members of the Department of Surgery of the WVU School of Medicine have written ehapters for textbooks used in the United States and other countries.

Dr. Bernard Zimmermann, Professor and Chairman of Surgery, contributed material on "Surgical Metabolism and Electrolyte Balance" for Christopher's Textbook on Surgery.

Dr. Walter H. Gerwig, Jr., of Clarksburg, Clinical Professor, and Doctor Zimmermann collaborated on a chapter on "The Large and Small Intestine" in the textbook, Physiological Principles of Surgery.

Dr. Walter H. Moran, Jr., Assistant Professor, prepared material for a chapter on the endocrine glands in the book, "Research Methods in Surgery," a new publication used as a guide for teaching ways to perform medical research.

Three Appointed to Faculty

Three new physicians joined the staff of the WVU School of Medicine during September.

Dr. Carlos Pinto of Sao Paulo, Brazil, accepted appointment as an instructor in pathology; Dr. Hun Ki Min of Seoul, Korea, as a research associate in internal medicine; and Dr. Un Kyong Lee, also of Seoul, as a resident in medicine.

62 More Beds Opened at Hospital

The West Virginia University Hospital, to meet an increasing demand for patient services, opened 62 additional beds during the months of September and October.

Hospital Director Eugene Staples said the hospital now has 362 beds and 20 bassinets in service. He said the hospital is aiming for a full capacity of 520 beds by January, 1966.

The additional beds are part of a program to expand services in neurology, orthopedics, pediatrics and medical and surgical chest problems. Staples said these beds and the 15 pediatric beds put into service last June are helping to meet the increasing demand for service from throughout West Virginia.

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The Month in Washington

A House-Senate conference committee deadlocked over the Johnson Administration's so-called medicare proposal before adjourning to campaign for the November elections. It meant the death of such legislation for this year unless Congress should be called back in special session after the elections for further consideration of the legislation by the conference committee.

However, medicare supporters said they would revive the issue next year and make another attempt to get Congressional approval for hospitalization for the aged financed by a social security tax increase.

Failure of the committee to reach agreement on medicare also killed a cash increase in social security benefits. The House overwhelmingly voted for the cash increase. The Senate voted 49-44 to add an administration proposal that would have financed some hospitalization and nursing home care for the aged under social security.

A majority of the House conferees—Ways and Means Committee Chairman Wilbur D. Mills (D. Ark.), Reps. John W. Byrnes (R., Wis.) and Thomas B. Curtis (R., Mo.)—stood pat against medicare. Democratic Reps. Cecil R. King (Calif.) and Hale Boggs (La.) voted for it.

Four of the seven Senate conferees voted to the last in the conference for medicare. All Democrats, they were Sens. Clinton P. Anderson (N. Mex.), George A. Smathers (Fla.), Russell B. Long (La.) and Albert Gore (Tenn.). Opposing medicare were Finance Committee Chairman Harry F. Byrd (D., Va.) and Sens. John J. Williams (R., Del.) and Frank Carlson (R. Kan.).

The conferees from each the Senate and the House voted as a group with a majority determining how the group vote is cast.

Denied Cash Benefits

Byrnes pointed out that the pro-medicare Senate conferees had denied an increase in social security cash benefits by refusing to have any bill approved if it didn't include medicare.

"Adequate cash benefits and medicare cannot both be financed through a social security tax," Byrnes said. "Adoption of the Senate Amendment would make it impossible, as a practical matter, to adjust cash benefits in order to meet increases in the cost of living. Cash benefits under social security would be 'frozen'."

Meantime, the federal-state Kerr-Mills is paying part or all of the costs of medical care, including hospitalization, for thousands of aged Americans who need such help.

• **From the Washington Office of the American Medical Association.**

Payments for medical care under the Nation's federally-aided public assistance programs neared the $1 billion mark in 1963—an increase of almost $150 million over 1962, according to recent Health, Education and Welfare Department figures.

Almost three-quarters of the total—nearly $745 million—was for medical assistance to the aged under the Kerr-Mills Old Age Assistance (OAA) and Medical Assistance for the Aged (MAA) programs. These costs alone increased by nearly $110 million over 1962.

MAA Totals $330 Million

Medical Assistance for the Aged totaled $330 million, an increase of $79 million over 1962, while medical care costs for recipients of Old Age Assistance totalled $415 million, an increase of $31 million over 1962. The MAA program covers the aged who can provide for themselves ordinarily but need help on their medical expenses. The OAA program provides medical care for the aged on public welfare rolls.

Total costs of medical care in 1963 for the needy aged, blind, disabled, and families with children totalled $964,276,000, a large percentage of which was paid for hospitalization.

The figures for 1963 showed that for the federally-aided programs:

—Hospital bills accounted for about 40 per cent of the expenditures, or $384,888,000, an increase of $52 million over 1962.

—Nursing homes received $333,867,000, an increase of $62 million over 1962.

—Physicians were paid $88,942,000, increased $7 million.

—Dentists received $21,203,000, increased $3 million.

—Drug payments totaled $89,216,000, increased $12 million.

—Various other services such as optometrists, podiatrists, special medical supplies, etc., totaled $46,072,000.

Medical care for needy children and their parents accounted for $111.7 million or $15 million over 1962. Recipients of aid to the permanently and totally disabled received medical care benefits of $97.9 million in 1963, about $21 million more than 1962; and aid to the needy blind medical care reached $10.8 million, an increase of $1 million.

Obituaries

COLIN ARTHUR ANDERSON, M. D.

Dr. Colin Arthur Anderson, 62, Superintendent of the West Virginia Training School at St. Marys, died on September 22 at his home in that community.

Doctor Anderson was born in Morpeth, England, May 17, 1902. He entered the British Merchant Service shortly after World War I and in 1923 joined the British Royal Air Force as a pilot officer, serving in the Middle East.

Following his military service, he returned to England and received his M. D. degree in 1938 from the University of Durham College of Medicine. He served an internship at the Naval Yard Hospital, Walker on Tyne, England, 1938-39.

Doctor Anderson entered private practice in Norwich, England, and in 1946 entered the University of Durham College of Dental Surgery receiving his D. D. S. degree in 1948.

He came to the United States in 1954 and served as a staff physician, chief of staff and assistant superintendent of the State Hospital in Butner, North Carolina, 1954-58, before assuming the post at St. Marys.

Besides his widow, he is survived by a brother and sister in England.

JAMES CLARK KILLEY, M. D.

Dr. James Clark Killey, 80, of Roanoke, Virginia, who practiced for many years in the Southern West Virginia coalfields, died on September 23 in a Roanoke hospital.

Doctor Killey was born on May 8, 1884, at Glen Lyn, Virginia, the son of the late Dr. Phillip H. and Elizabeth Clark Killey. He attended Roanoke College in Salem, Virginia, and received his M. D. degree in 1907 from the Medical College of Virginia in Richmond.

He served an internship at Memorial Hospital in Richmond, 1907-08, and was licensed to practice in West Virginia in 1908.

Doctor Killey practiced in the McDowell County area until his retirement in 1945. He was a past president and secretary of the McDowell County Medical Society and a former member of the West Virginia State Medical Association.

Besides his widow, he is survived by a daughter, Mrs. George W. Henderson, Jr., of Atlanta, Georgia, and a brother, R. M. Killey of Charleston, South Carolina.

* * * *

JOHN FOSTER LEHMAN, M. D.

Dr. John Fosier Lehman, 55, of Kingwood, died on October 5 at his home in that city after a brief illness.

He was born on December 13, 1908, at Madera, Pennsylvania, the son of the late Louis Lehman and Mrs. Ruby Schoff Lehman. He was graduated from

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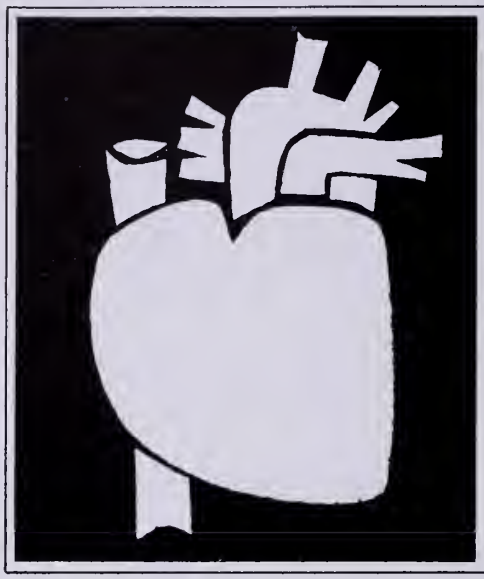

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Provides long-term coronary vasodilation[1-11, 16]

Plus long-term control of anxiety in heart disease[12-16]

REFERENCES: 1. Collicelli, A., and Nardelli, A.: Treatment of angina pectoris with a combination of pentaerythritol tetranitrate and meprobamate. Policlinico (Prat.) 67:441, Mar. 28, 1960. 2. Marche, J.: Pentaerythritol tetranitrate (pentrite or pentanitrine)—a coronary vasodilator with prolonged action. J. Med. Chir. Prat. (In French) 121:252, Nov. 1950. 3. Plotz, M.: Pentaerythritol tetranitrate: A new drug for the treatment of coronary insufficiency. N. Y. J. Med. 52:2012, Aug. 15, 1952. 4. Plotz, M.: The treatment of angina pectoris with a new prolonged action pentaerythritol tetranitrate. Amer. J. Med. Sci. 239:194, Feb. 1960. 5. Russek, H. I., Urback, K. F., Goerner, A. A. and Zohman, B. L.: Choice of a coronary vasodilator drug in clinical practice. JAMA 153:207, Sept. 19, 1953. 6. Russek, H. I., Zohman, B. L. and Gorset, V. J.: Objective evaluation of coronary vasodilator drugs. Amer. J. Med. Sci. 229:46, Jan. 1955. 7. Russek, H. I., Zohman, B. L., Drumm, A. E., Weingarten, W. and Dorset, V. J.: Long-acting coronary vasodilator drugs: Metamine, Paverii, Nitroglyn, and Peritrate. Circulation 12:169, Aug. 1955. 8. Russek, H. I.: Evaluation of drugs used in the treatment of angina pectoris by means of exercise-electrocardiographic tests. Ann. N. Y. Acad. Sci. 64:533, Nov. 16, 1956. 9. Talley, R. W., Beard, O. W., and Goherty, J. E.: Use of pentaerythritol tetranitrate (Peritrate) in treatment of angina pectoris. Amer. Heart J. 44:866, Dec. 1952. 10. Winsor, T. and Humphreys, P.: Influence of pentaerythritol tetranitrate (Peritrate) on acute and chronic coronary insufficiency. Angiol. 3:1, Feb. 1952. 11. Eskwith, I. S.: Holistic approach in the management of angina pectoris. Postgrad. Med. 27:203, Feb. 1960. 12. Friedlander, H. S.: The role of ataraxics in cardiology. J. Cardiol. 1:395, Mar. 1958. 13. Russek, H. I.: Meprobamate in the treatment of angina pectoris. Amer. J. Cardiol. 3:547, Apr. 1959. 14. Shapiro, S: Observations on the use of meprobamate in cardiovascular disorders. Angiol. 8:504, Dec. 1957. 15. Waldman, S. and Peiner, L.: Modification of the anxiety state associated with myocardial infarction by meprobamate: preliminary notes. N. Y. J. Med. 58:1285, Apr. 15, 1958. 16. Koehnke, F. K.: Treatment of angina pectoris of functional origin with Corneural. Med. Klin. 54:1435, Aug. 1959.

Indications: 'Miltrate' is useful for prophylaxis of pain in angina pectoris and coronary insufficiency, especially where anxiety is a factor. **Contraindications:** Like all nitrates, pentaerythritol tetranitrate should be avoided or prescribed cautiously for patients with glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use. **Precautions:** *Meprobamate* —Patients engaged in activities requiring alertness should be warned of drowsiness. Meprobamate may increase the effects of excessive alcohol, and the possibility of dependence should be considered, particularly in patients with a history of drug or alcohol addiction. Sudden withdrawal may result in reactions, rarely epileptiform seizures. Grand mal attacks may be precipitated in persons susceptible to both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies. **Side effects:** *Pentaerythritol tetranitrate* —The most common side effects are transient headache, nausea, and rash. Weakness, palpitation, flushing, gastrointestinal distress, and lightheadedness have been reported on a few occasions. *Meprobamate* —May cause drowsiness and, rarely, ataxia, usually controlled by decreasing the dosage. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses of the drug. Mild reactions include urticarial or maculopapular rash. Serious reactions, rarely encountered, include dermatological effects, acute nonthrombocytopenic purpura, chills, fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises, anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic, and the drug not be reinstituted. **Dosage:** Usual dosage is one or two tablets before meals and at bedtime. Individualization of dosage is required for maximum therapeutic effect. Doses above twelve tablets daily are not recommended. **Supplied:** White tablets, each containing meprobamate 200 mg. and pentaerythritol tetranitrate 10 mg. *Before prescribing, consult package circular.*

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Bucknell University and received his M. D. degree in 1935 from Jefferson Medical College in Philadelphia.

Doctor Lehman served an internship at the Delaware Hospital in Wilmington, 1935-36. He was licensed to practice in West Virginia in 1936 and that same year was sent by the Quakers Society to Arthurdale in Preston County, where he practiced for three years before moving to Kingwood.

During World War II, he served in the Medical Corps of the United States Navy in the South Pacific. He was a member of the Preston County Medical Society, West Virginia State Medical Association and American Medical Association.

Besides his widow, he is survived by his mother, Mrs. Ruby Schoff Lehman of Madera, Pennsylvania, one daughter, Mrs. Joseph Schmidle, III, of Kingwood, and two sons, John Glen and Gregg Lee Lehman, both of Kingwood.

Medical Seminar Cruise

The 6th Postgraduate Medical Seminar Cruise sponsored by Albany Medical College of Union University will depart from New York on January 6.

Members of the Albany Medical College faculty will present a comprehensive postgraduate program during the 14-day cruise aboard the M. S. Gripsholm.

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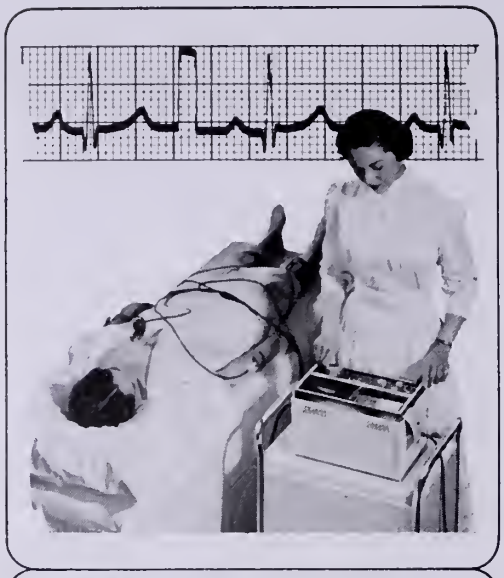

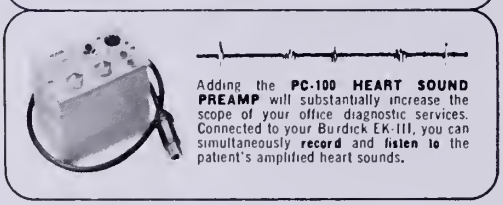

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County Societies

McDOWELL

Dr. Charles F. McCord was the speaker at the regular monthly meeting of the McDowell County Medical Society which was held at Grace Hospital in Welch on September 16.

Doctor McCord, a member of the Grace Hospital staff, discussed the use of tonometry and recent concepts in the treatment of glaucoma. He demonstrated the use of a tonometer, pointing out the feasibility of using it regularly on routine medical examinations.

Dr. John S. Cook, the president, presided at the business meeting. The Society approved a resolution endorsing the location of a proposed Regional Public Health Center in McDowell County. The resolution was forwarded to State Director of Health Dr. N. H. Dyer.—David J. Skewes, M. D., Secretary.

* * * *

RALEIGH

Dr. Barbara Jones of Morgantown was the guest speaker at the first fall meeting of the Raleigh County Medical Society which was held at the El Chico Restaurant in Beckley on Sept. 17.

Doctor Jones, Associate Professor of Pediatrics at the West Virginia University School of Medicine, discussed "Current Trends in the Treatment of Leukemia." She was introduced by Dr. Werner A. Laqueur.

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21st ANNUAL CONFERENCE IN CHICAGO

The 21st Annual Conference of State Presidents, Presidents Elect, National Officers and Committee Chairmen of the Woman's Auxiliary to the American Medical Association was held at the Drake Hotel in Chicago, October 4-7.

Attending from West Virginia were Mrs. George A. Curry of Morgantown, President of the Woman's Auxiliary to the West Virginia State Medical Association; Mrs. Wilson P. Smith of Huntington, President Elect of the State Auxiliary; and Mrs. Pat A. Tuckwiller of Charleston, immediate past president of the State Auxiliary and now National Regional Chairman of the Rural Health Committee.

Mrs. William H. Evans of Youngstown, Ohio, President of the National Auxiliary, welcomed the conferees on Monday morning, October 5. Mrs. Richard A. Sutter of St. Louis, Missouri, the president elect, presided at the conference which had as its theme, "Better Health—Better World."

Sen. Everett M. Dirksen of Illinois was the guest speaker at the AMPAC dinner which was held on Sunday evening, October 4. Choosing as his subject, "We Do Not Want to Remake America," he held his audience spellbound.

Speakers appearing on the formal program included:

Dr. F. J. L. Blasingame, Executive Vice President of the American Medical Association; the Rev. Paul B. McCleave, Director of the Department of Medicine and Religion; Dr. Edward R. Annis, immediate past president of the AMA; Dr. W. Wyan Washburn of Boiling Springs, North Carolina, Chairman of the Council on Rural Health; Dr. Ernest B. Howard, Assistant Executive Vice President of the AMA; and Mr. Robert A. Enlow, Director of the AMA's Circulation and Records Department.

The writer was most impressed by the friendliness of the more than 200 conferees which represented all of the 50 states. There were no strangers among us. A magic word—friendliness—really makes life worth living.—Mrs. Wilson P. Smith, President Elect.

HARRISON

The annual fall tea of the Woman's Auxiliary to the Harrison County Medical Society was held at the home of Dr. and Mrs. L. Dale Simmons in Clarksburg on September 10. The tea was attended by 46 members and guests.

Mrs. John D. H. Wilson, the president, headed the receiving line composed of Mrs. Herbert N. Shanes of Grafton, first vice president of the State Auxiliary; Mrs. Albin A. Galuszka, vice president of the local Auxiliary; and Mrs. Hugh M. Brown, social chairman.

Mrs. Wilson welcomed members and guests and introduced a new member, Mrs. E. A. Burkhard of Clarksburg.

Dr. Albert C. Esposito of Huntington was the guest speaker at a joint dinner meeting of the Harrison County Medical Society and the Woman's Auxiliary which was held at the Stonewall Jackson Hotel in Clarksburg on Thursday, October 1.

Doctor Esposito, who is President of the State Medical Association, presented an interesting talk on medical care in the State and legislative matters on the state and national level.

Dr. A. Robert Marks, President of the Society, and Mrs. John D. H. Wilson, President of the Auxiliary, presided at the meeting.—Mrs. Karl A. Dillinger, Press and Publicity.

* * * *

KANAWHA

Seventy-one members and guests attended the 40th anniversary luncheon meeting of the Woman's Auxiliary to the Kanawha Medical Society which was held at the home of Dr. and Mrs. Earle L. Shamblen in Charleston on September 8.

Past presidents of the Auxiliary were honor guests. Those attending included Mrs. T. Maxfield Barber, Mrs. M. I. Mendelhoff, Mrs. V. T. Churchman, Mrs. R. H. Walker, Mrs. John M. Moore, Mrs. Russel Kessel, Mrs. Randolph L. Anderson, Mrs. Arthur C. Chandler, Mrs. Pat A. Tuckwiller, Mrs. Newman H. Newhouse, Mrs. W. Paul Elkin, Mrs. J. Paul Aliff and Mrs. Joseph A. Smith.

Mrs. Earl A. McCowen, the president, and Mrs. James H. Walker and Mrs. Shamblen, president elect and hostess, received the guests.

Mrs. McCowen presided at the business meeting. Special projects approved included the hearing test program in schools; clothing chest; recruitment, cancer closet; safety and civil defense, mental health, community service; nutrition; and rural health.

Mrs. Carl J. Roncaglione, legislative chairman, discussed pending legislation before Congress and Mrs. Willis D. Garrard reported on tours to be conducted at Charleston and South Charleston hospitals.—Mrs. Arthur A. Abplanalp, Publicity Chairman.

* * * *

MARION

The Woman's Auxiliary to the Marion County Medical Society held its annual membership tea at the home of Dr. and Mrs. Robert B. Hamilton in Fairmont on September 29.

Mrs. F. W. Mallamo, the president, presided at the meeting which was attended by Mrs. George A. Curry of Morgantown, President of the Woman's Auxiliary to the West Virginia State Medical Association.

Mrs. Herbert N. Shanes of Grafton, first vice president of the State Auxiliary, and Mrs. Maynard P. Pride of Morgantown, the corresponding secretary, also attended.

* * * *

MERCER

Dr. John J. Mahood of Bluefield was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Mercer County Medical Society which was held at the YMCA Center in Bluefield on Sept. 21.

Doctor Mahood, president of the Mercer County Medical Society, was introduced by his wife, who serves as program chairman for the Auxiliary. He discussed his recent visit to the U. S. Public Health Service's National Leprosarium in Carville, Louisiana.

Mrs. Joe E. McCary, the president, presided at the business meeting and Mrs. Mahood presented a report on the 40th Annual Meeting of the Woman's Auxiliary to the State Medical Association at The Greenbrier in White Sulphur Springs, August 20-22.

Mrs. R. S. Gatherum, Jr., project chairman, gave a detailed report on the dispensary at Camp Joy, a project inaugurated by the Auxiliary last year.

MONONGALIA

The Woman's Auxiliary to the Monongalia County Medical Society held a coffee honoring prospective members at the home of Dr. and Mrs. Bernard Zimmermann in Morgantown in September.

Guests were recived by the hostess, Mrs. Zimmermann, and the president, Mrs. Aruthr W. Kelley. Programs for the year were distributed to the 41 members and guests who attended.—Mrs. Hubert A. Shaffer, Corresponding Secretary.

* * * *

RALEIGH

More than 50 members and guests attended a luncheon meeting of the Woman's Auxiliary to the Raleigh County Medical Society which was held at the Beckley Hotel in Beckley on September 21.

Mrs. Charles W. Merritt, the president, presided at the business meeting. The Auxiliary approved continuance of its assistance with the tuberculin testing program; nurses scholarship; AMA-ERF; Camp Gallahad; mental health; Health Careers Day for high school students; and the Crippled Children's Clinic.

Mrs. Thomas L. Martin, vice president and program chairman, introduced Ethel and Eva Keyser who presented a program of slides and commentary on their visit to Russia.—Mrs. John E. McKenzie, Press and Publicity.

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CONTENTS

Scientific Articles

Islet Cell Tumors of the Pancreas—H. Carl Wasson, Jr., M. D., F. L. Coffey, M. D., and G. F. Woelfel, M. D. 351

Hypoglycemia Following Sulfonylurea Therapy—A. B. Curry Ellison, M. D., William C. Stewart, M. D., and Alfred K. Pfister, M. D. 356

Report of the School of Medicine at West Virginia University—Clark K. Sleeth, M. D., Dean 360

The President's Page

Your Christmas Gift—Albert C. Esposito, M.D., President, West Virginia State Medical Association 366

Editorials

Foreign Students in United States Medical Schools 367
Nightmare 368
Christmas and the Microscope 368

General News

Report of Fall Council Meeting 369
Publication Committee Election 371
Fall Conference of Woman's Auxiliary 372
Doctor Lyon Retiring as VA Hospital Head 373

Special Departments

WVU Medical Center News xxiv
The Month in Washington xxvi
Obituaries xxix
County Societies xxxii
The Woman's Auxiliary xxxiv
Correspondence xxxvi
Index to Volume LX xl
Directory of Physicians in Limited Practice xliii
Index to Advertisers xlvi

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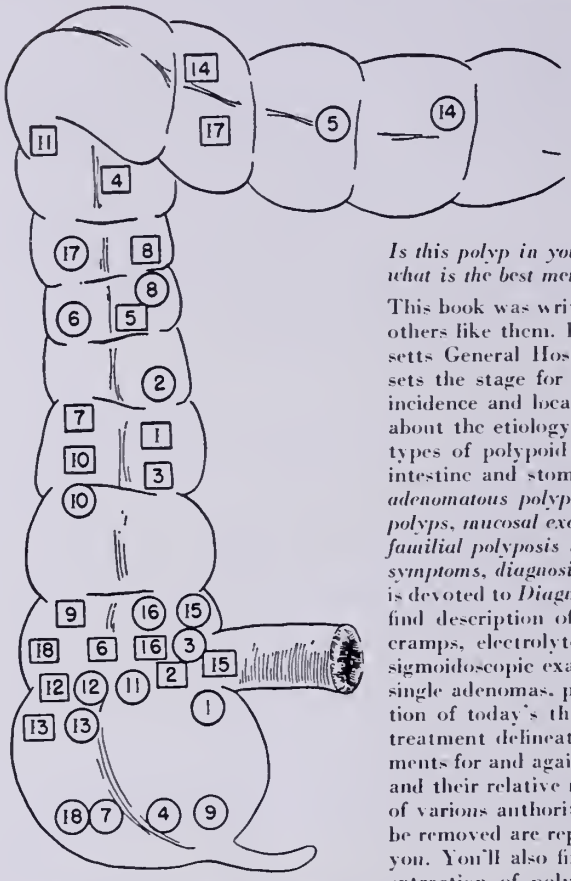

Figure 3-25. *Location of cancer and simple adenomas in resected cancers of the right colon. Squares locate cancers; circles, adenomas.*

Polypoid Lesions of the Gastrointestinal Tract

by Claude E. Welch, M.D.

Is this polyp in your patient benign or malignant? Should it be removed? If so, what is the best method for this particular lesion in this particular patient?

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1. Welch, C. E., Diverticula of the Alimentary Tract, in Conn, H. (editor): Current Therapy—1961, Philadelphia, W. B. Saunders Company, 1961, pp. 224-225.

SEARLE

Research in the Service of Medicine

WVU Medical Center
—News—

Dr. Heinz J. Wittig, a native of Munich, Germany, has been appointed Assistant Professor and Head of the Division of Pediatric Allergy at the West Virginia University School of Medicine. Doctor Wittig succeeds Dr. Robert J. Nottingham, who is now practicing in Denver, Colorado.

Heinz J. Wittig, M. D.

Doctor Wittig received his M.D. degree in 1950 from the University Faculty of Medicine in his native Munich. He served an internship and residency in pediatrics at St. Thomas Hospital in Nashville, Tennessee, 1951-53.

Before joining the WVU faculty, he was director of the Department of Pediatric Allergy at Seton Hall University School of Medicine in South Orange, New Jersey.

Doctor Wittig received his pediatric allergy training under Dr. Jerome Glaser at the University of Rochester School of Medicine. He served as clinical instructor at both the University of Illinois and New York University Schools of Medicine and was Chief of Pediatrics at the United States Army Hospital in Verdun, France, during his tour of duty as a Captain in the Medical Corps of the United States Army, 1955-57.

He was certified in 1956 by the American Board of Pediatrics in Pediatric Allergy. He is a member of the American Medical Association, American Academy of Pediatrics, American Academy of Allergy and the Association of American Medical Colleges.

Enrollment Climbs

Two hundred and thirty-eight students have enrolled for the first semester in the WVU School of Medicine. This is an increase of 20 students over the first semester enrollment of 1963.

Dr. Kenneth E. Penrod, Vice President in charge of the Medical Center, said total enrollment at the Medical Center for the first semester was 868, up 43 from the 1963 figure.

In addition to medicine, programs are offered in medical technology, dentistry, dental hygiene, nursing and pharmacy.

• **Compiled from material furnished by Arthur V. Ciervo, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

Three Present Papers at ACS Meeting

Three members of the Department of Surgery faculty at the WVU School of Medicine presented papers at the Annual Clinical Congress of the American College of Surgeons in Chicago, October 5-9.

Dr. Bernard Zimmermann, Professor and Chairman of Surgery, presided at a four-day course on Pre- and Post-Operative Care and presented a paper on "Physiologic Mechanisms for Protection of Circulating Volume."

Dr. Edgar F. Heiskell of Morgantown, Clinical Assistant Professor of Surgery, presented a paper on "Tetanus: Prophylaxis and Treatment."

Dr. Thomas J. Tarnay, Instructor in Surgery, discussed "Isolated Annulus: A Method for the Evaluation of Intracardiac Prosthetic Thrombosis." This paper was prepared in collaboration with Dr. Herbert E. Warden, Professor of Surgery.

Doctor Chang Honored

Dr. C. H. Joseph Chang, formerly of Logan, was elected a member of the American Roentgen Ray Society at its recent meeting in Minneapolis, Minnesota.

Doctor Chang, an Associate Professor of Radiology, is a Diplomate of the American Board of Radiology and has had papers published in several scientific journals.

Take Classrooms to Physicians

Four members of the WVU School of Medicine faculty took their classrooms to West Virginia physicians on Sunday, November 8, when they presented a pilot program at the Fairmont Hotel in Fairmont.

The project, known as Comprehensive Clinical Courses, was sponsored by the West Virginia Chapter of the American Academy of General Practice.

The School of Medicine participants were Drs. William E. Anderson, Assistant Professor of Medicine; Alvin L. Watne, Associate Professor of Surgery; Dean R. Goplerud, Assistant Professor of Obstetrics and Gynecology; and Heinz J. Wittig, Assistant Professor and Head of the Department of Pediatric Allergy.

Each delivered two lectures, one in the morning session on "Signs and Symptoms," and the second during the afternoon segment devoted to "Differential Diagnosis." A critique and summary followed.

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The Month in Washington

• From the Washington Office of the American Medical Association.

THE Johnson Administration has placed so-called medicare at the top of its legislative program for 1965. In a policy paper issued a few days before the national elections, President Johnson said:

"First we must provide adequate hospital and nursing home care for our senior citizens by a sound program financed through contributory social insurance. I pledge that the legislation to accomplish this will head my program next year."

Administration forces in Congress expressed confidence that most of Johnson's legislative program would be approved next year in light of the Democratic victory in the elections. Democrats gained a net of 37 seats in the House. The Administration was reported to be considering a program that would be financed by a separate employer-employe tax rather than an increase in the social security tax as called for in legislation that died in a House-Senate conference committee when Congress adjourned in October.

Solutions May Be Within Reach

In reiterating his opposition to social security financing, Rep. Wilbur D. Mills, D., Ark., chairman of the Ways and Means Committee, said just prior to adjournment:

"I think one of the difficulties that has actually impeded the reaching of a sound solution is the insistence by the proponents of medical care on proceeding toward a solution through the existing OASDI (Social Security), system rather than in an all-out effort to solve the problem itself with some flexibility in their approach. In other words, there may well be within our reach solutions to the admittedly difficult and increasing problems of medical care for the aged which lie outside of attaching a Federal program to the framework of the OASDI insurance system.

"I would be hopeful that the basic prepayment concept might lead us in the direction of sound approaches to this matter. There are other principles which we can embody to insure a sound medical program while at the same time preserving our basic social security insurance system."

Stepped Up Fight on Mental Health

Other points listed in Johnson's policy paper on health were:

"Second, we must step up the fight on mental health and mental retardation. I intend to ask for increased funds for research centers, for special teacher training, and for helping coordinated state and local programs.

"Third, we must expand our program to help train the doctors, dentists and technicians this nation desperately needs. Right now, the statistics show that we are importing interns and resident physicians from other countries which can ill afford to lose them.

"Fourth, we must enlarge programs to help disabled citizens rehabilitate themselves for useful employment.

"Fifth, we must increase existing programs of medical assistance to children of low-income families.

"Sixth, we must work to correct the deficiencies of young men who are rejected for military service because of health.

"Seventh, we must move ahead in the effort to protect the purity of the water we drink and the air we breathe. Air pollution, according to one estimate, causes $11 billion damage each year to property alone. No one can measure the damage to our children's lungs."

$35 Million for Centers

A total of $35 million in Federal funds has been appropriated to help finance construction of community mental health centers in 1965.

It is the initial allotment of funds for a $150 million three-year program of Federal grants-in-aid for building such centers. Grants will range from one-third to two-thirds of total construction costs.

The Department of Health, Education and Welfare said the centers built in 1965 will form the nucleus of the new national mental health program to provide comprehensive treatment of the mentally ill in the patients' home communities.

Grants will be administered and awarded to eligible sponsors of the centers by the National Institute of Mental Health of the Public Health Service under terms of the Community Mental Health Centers Construction Act of 1963 (Public Law 88-164).

The centers must provide a minimum of the following five essential services to patients: inpatient treatment, outpatient treatment, partial hospitalization, with around-the-clock emergency service available in at least one of these. Centers must also provide consultation and educational services to community agencies.

Obituaries

JAMES EDWARD WILSON, M. D.

Dr. James Edward Wilson, 83, of Clarksburg, whose four sons are physicians, died on October 10 at his home in that city after an extended illness.

Doctor Wilson was born on August 3, 1881, at Princess Anne, Maryland, the son of Levin James and Mary Evalyn Daugherty Wilson.

He received his M. D. degree in 1904 from the College of Physicians and Surgeons in Baltimore, Maryland, and was licensed to practice in West Virginia the following year.

Doctor Wilson opened his practice in Clarksburg and in 1907 brought the first x-ray equipment to that city. He was the founder of the x-ray department at St. Mary's Hospital in Clarksburg.

He was also active in civic and government affairs. He was a member of the Clarksburg city council in the 1920's which was responsible for major reforms in the city government.

Doctor Wilson also was one of the founders of the Monongahela Valley Hospital Service, Inc., in the 1930's. He was a past president of the organization which served as a pioneer in the Blue Shield plans throughout the United States.

Doctor Wilson was a past president and secretary of the Harrison County Medical Society. He also was a member of the West Virginia State Medical Association, American Medical Association and was a Diplomate of the American Board of Radiology.

Besides his widow, the former Mary E. Boggess, he is survived by Drs. James E. Wilson, Jr., J. D. H. Wilson and Robert S. Wilson, all of Clarksburg; and Dr. Thomas C. Wilson of Baltimore, and six daughters, Mrs. Sidney H. Beauchamp and Mrs. Thomas J. Moore of Clarksburg; Mrs. Robert S. Thomson of Fitchburg, Massachusetts; Mrs. James L. Morris of Denver, Colorado; Mrs. James F. Gleason of Ventor, New Jersey; and Mrs. J. Thomas Greene of Charleston.

PG Course on Treatment of Cancer

A postgraduate course in surgery on "Treatment of Cancer" will be presented by the Cleveland Clinic Educational Foundation in Cleveland, January 13-14, 1965.

Guest speakers include Dr. Robert J. Izant, Jr., Assistant Professor of Surgery and Director of Pediatric Surgery at the University Hospitals in Cleveland; Dr. B. J. Kennedy of Minneapolis, Associate Professor of Medicine at the University of Minnesota Medical Center; and Dr. Walter T. Murphy of Buffalo, New York, Chief of the Department of Radiation Therapy at Buffalo General Hospital.

The registration fee is $30 and further information may be obtained by writing Dr. Walter J. Zeiter, Director of Education, The Cleveland Clinic Education Foundation, 2020 E. 93rd Street, Cleveland, Ohio 44106.

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ERNEST G. GUY, M. D.

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County Societies

BARBOUR-RANDOLPH-TUCKER

Dr. Jack C. Morgan of Fairmont was the guest speaker at the regular monthly meeting of the Barbour-Randolph-Tucker Medical Society which was held at Blackwater Falls Lodge on October 15.

Doctor Morgan presented an interesting paper on "Hemoptysis of Undertermined Origin," and he pointed out the fact that up to 35 per cent of patients with hemoptysis may not have any etiological causes at the time of first consultation but later may develop etiological agents. He said that it was wise to follow all cases at regular intervals.

Dr. A. C. Thompson, the first vice president, presided at the meeting and there was general discussion concerning the King-Anderson Bill. It was pointed out that the Society had undertaken a program to acquaint citizens with the Kerr-Mills law which cares for the elderly who are in need.

The meeting was attended by 13 members.—A. Kyle Bush, M. D., Secretary.

* * * *

CABELL

Dr. Walter R. Wilkinson was elected president of the Cabell County Medical Society during the regular monthly meeting which was held at the Hotel Fred-

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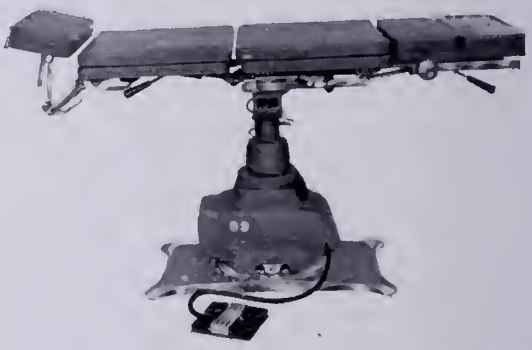

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erick in Huntington on October 8. Other new officers for the coming year are as follows:

Drs. Joseph M. Ferrell, president elect; W. L. Neal, vice president; Harold N. Kagan, secretary; and John F. Otto, Jr., treasurer.

Dr. C. H. Boso presided at the meeting and the speaker was Mrs. Lyda Plymale, president of the West Virginia Association of Medical Assistants. She outlined briefly the nature and purpose of the organization and said that it strives to promote better office service for the individual physician, better public relations for the medical profession and better education and fellowship for its members.

Elected to membership during the business meeting were Drs. Jeb C. Burton, Jr., and Herbert D. Proctor.—W. L. Neal, M. D., Secretary.

* * * *

KANAWHA

Mr. Paul L. Selby, Jr., new Dean of the West Virginia University College of Law, was the speaker at the annual joint meeting of the Kanawha Medical Society and Kanawha County Bar Association which was held at the Daniel Boone Hotel in Charleston on October 13.

Dean Selby said that "the courtroom is the great barrier that divides doctors and lawyers, the place where the seeds of mistrust are sown and flourish."

He said that physicians feel the trial court process is inefficient, inequitable and uncertain and that lawyers are trying to make money instead of seeking justice.

On the other hand, he said lawyers feel doctors are uncooperative, tend to be too technical and are more apt to serve as witnesses for the prosecution rather than the defense.

Dean Selby said there should be more pre-trial conferences between physicians and attorneys "to narrow the differences and to gain greater respect for each other."

* * * *

MERCER

The regular monthly meeting of the Mercer County Medical Society was held in Bluefield on September 21.

Dr. John J. Mahood was the speaker and he presented an interesting and informative paper on Hansen's Disease.

The Society gave its unanimous approval to a motion to forward a letter of sympathy to the widow of the late Dr. Norman A. Welch, President of the American Medical Association.—J. Brookins Taylor, M. D., Secretary.

* * * *

MONONGALIA

Mr. John Hillin of Charleston was the guest speaker at the regular monthly meeting of the Monongalia County Medical Society which was held in Morgantown on September 1.

Mr. Hillin, a member of the staff of the Bureau of Venereal Disease Control of the State Department of

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AUDIOLOGY AND SPEECH PATHOLOGY
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Health, discussed the increase in VD and methods for its prevention and definitive diagnosis in unusual cases.

Dr. L. A. Dickerson of Charleston, Director of the Disease Control Division of the State Department of Health, presented a summary for the proposed cooperative program of comprehensive health services for welfare recipients in the Monongalia County area.

Drs. Thomas M. Howes and John H. Wolf, Jr., were unanimously elected to membership in the Society and Dr. Francisco Gutierrez an associate member.—W. E. King, M. D., Secretary.

Ob. & Gyn. Examinations

The American Board of Obstetrics and Gynecology has announced that candidates participating in the Part I (written) examination to be given on December 11 will be notified of the results on or before February 1, 1965.

All candidates who have completed 18 months each of approved progressive residency training in clinical obstetrics and clinical gynecology by June 30, 1965, will be eligible to apply for admission to the Part I (written) examination to be held on July 2, 1965.

Application forms and current bulletins may be obtained by writing to the secretary, Dr. Clyde L. Randall, American Board of Obstetrics and Gynecology, 100 Meadow Road, Buffalo, New York 14216. Applications postmarked after February 28, 1965, will not be accepted.

Woman's Auxiliary

to the

WEST VIRGINIA STATE MEDICAL ASSOCIATION

President: Mrs. George A. Curry, Morgantown
President Elect: Mrs. Wilson P. Smith, Huntington
First Vice President: Mrs. Herbert N. Shanes, Grafton
Second Vice President: Mrs. C. J. Holley, Wheeling
Third Vice President: Mrs. J. A. B. Holt, Charleston
Fourth Vice President: Mrs. Ray M. Kessel, Logan
Treasurer: Mrs. J. Dennis Kugel, Charleston
Recording Secretary: Mrs. Robert J. Tchou, Williamson
Corresponding Secretary: Mrs. Maynard P. Pride, Morgantown
Parliamentarian: Mrs. William R. Rice, Dunbar.

CENTRAL WEST VIRGINIA

A reception honoring Dr. Albert C. Esposito of Huntington, President of the State Medical Association, preceded the annual joint dinner meeting of the Central West Virginia Medical Society and Auxiliary at West Virginia Wesleyan College in Buckhannon on September 30.

Other honored guests were Mrs. Esposito; Mrs. Pat A. Tuckwiller of Charleston, immediate past president of the Woman's Auxiliary to the State Medical Association; Mr. William H. Lively and Mr. Jerry Gould of

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Charleston, executive secretary and executive assistant respectively, of the State Medical Association; and instructors in the new Wesleyan School of Nursing.

Doctor Esposito stressed the importance of active participation in political campaigns and elections in his brief address. He said that Socialized Medicine is a very real threat.

The Auxiliary voted to support AMA-ERF, Health Careers and HOPE at its business meeting and approved a contribution to the Wesleyan School of Nursing.—Mrs. John E. Echols, Correspondent.

* * * *

HARRISON

Mrs. Arthur C. Chandler of Charleston was the guest speaker at the regular monthly meeting of the Woman's Auxiliary to the Harrison County Medical Society which was held at the Stonewall Jackson Hotel in Clarksburg on November 5.

Mrs. Chandler, who accompanied her ophthalmologist husband on the hospital training ship Hope to Guayaquil, Ecuador, explained that the vessel's name stands for "Health Opportunities for People Everywhere."

She said the object of the ship as a teaching institution was to take the best of this country's medical and dental techniques to foreign countries.

Mrs. J. D. H. Wilson, the president, presided at the business meeting and Mrs. James A. Thompson introduced the special guests, Mrs. George A. Curry of Morgantown and Mrs. Pat A. Tuckwiller of Charleston, president and immediate past president of the Woman's Auxiliary to the West Virginia State Medical Association.—Mrs. Karl A. Dillinger, Press and Publicity.

* * * *

KANAWHA

The regular monthly meeting of the Woman's Auxiliary to the Kanawha Medical Society was held at the home of Dr. and Mrs. Paul Francke, Jr., in Charleston on October 13.

Mrs. Earl A. McCowen, the president, presided at the business meeting. Plans were announced for hospital tours for high school students on October 27.

The participating hospitals were Charleston General with Mrs. George V. Hamrick as chairman; Charleston Memorial, Mrs. Harry A. Jackson; and Thomas Memorial, Mrs. R. E. Pence.

Contributions were made to special projects in lieu of sending Christmas cards to the families of other physicians. One card, sent by the Auxiliary, will represent all who contribute.

Sixty members and three guests attended the meeting. Mrs. Andrew W. Goodwin, II, and Mrs. William C. Revercomb, Jr., were co-chairmen.—Mrs. Arthur A. Abplanalp, Publicity Chairman.

* * * *

MARION

Mr. William H. Lively of Charleston, Executive Secretary of the West Virginia State Medical Association, was the speaker at a joint meeting of the Marion County Medical Society and Woman's Auxiliary at the Fairmont Hotel in Fairmont on October 27.

The speaker, who was introduced by Dr. Robert B. Hamilton, presented an interesting and informative talk on "Present and Pending Legislation Regarding Doctors in West Virginia."

Dr. William T. Lawson, the president, presided at the business meeting. Dr. Seigle W. Parks, named president elect of the State Medical Association at its annual meeting in August at The Greenbrier, was introduced.

Those assisting with arrangements for the meeting included Mrs. F. W. Mallamo, Auxiliary president, Mrs. John J. Coogle, Mrs. Jack C. Morgan, Mrs. Robert J. Sidow, Mrs. Joseph D. Romino, Mrs. C. L. Kinney, Mrs. Robert B. Hamilton, Dr. and Mrs. Rupert W. Powell and Mrs. Carter F. Cort.—Mrs. William T. Lawson, Correspondent.

* * * *

McDOWELL

The Woman's Auxiliary to the McDowell County Medical Society held its first meeting of the fall season at the home of Mrs. Arthur Allen Carr in War on September 23.

Mrs. A. B. Carr of Bradshaw served as co-hostess. The meeting was attended by 12 members and two guests.

———

The annual benefit bridge sponsored by the Woman's Auxiliary to the McDowell County Medical Society was held at the Legion Club in Welch on October 14.

Members of the Health Careers Club assisted with the affair which had 32 tables in play. Proceeds are used for crippled children and the health career scholarship fund.

Mrs. John S. Cook served as chairman for the bridge. She was assisted by Mesdames John H. Murry, Jorge Ribeiro and Louis A. Vega.—Mrs. John H. Murry, Secretary.

* * * *

MERCER

Past presidents of the Woman's Auxiliary to the Mercer County Medical Society were honored at its October meeting at the Tow'N Country Restaurant in Princeton.

Those attending included Mrs. Frederic C. Goodall, Mrs. Gordon L. Todd, Mrs. W. F. Hillier, Jr., Mrs. Roy R. Raub, Mrs. E. Lyle Gage, Mrs. J. E. Blaydes, Jr., Mrs. Paul Champion, Mrs. Upshur Higginbotham, Mrs. D. V. Kechle, Mrs. Richard O. Rogers, Sr., and Mrs. Cecil F. Johnston.

Mrs. John J. Mahood, the program chairman, introduced the past presidents. Each gave a brief resume of the Auxiliary activities during their term of office.

Mrs. Joe E. McCary, the president, extended a welcome to the former officers and gave a brief history

of the formation of the Woman's Auxiliary to the American Medical Association.

* * * *

MONONGALIA

The regular monthly meeting of the Woman's Auxiliary to the Monongalia County Medical Society was held at the Lakeview Country Club near Morgantown on October 6.

Mrs. Arthur W. Kelley, the president, presided at the business meeting. Mrs. Thomas M. Howes, a new member, was introduced.

Hostesses for the luncheon meeting were Mesdames Lawrence S. Miller, W. M. Warman, Maynard P. Pride, Ralph W. Ryan, Herbert V. King, Arthur W. Kelley and George A. Curry.—Mrs. James Hugh Wiley.

* * * *

RALEIGH

Mrs. George A. Curry of Morgantown, president of the Woman's Auxiliary to the West Virginia State Medical Association, was the speaker at the regular monthly meeting of the Woman's Auxiliary to the Raleigh County Medical Society which was held at the Beckley Hotel in Beckley on October 19.

Mrs. Curry, who was introduced by Mrs. Thomas L. Martin, said that for 42 years Auxiliary members have taken the lead in making their own communities a better place in which to live.

She said the scope of this work must be broadened and to do this, membership in the Auxiliary must be increased. She urged her audience to promote interest in the organization among doctors' wives.

Mrs. Charles W. Merritt, the president, introduced Mrs. John A. B. Holt of Charleston, third vice president of the State Auxiliary, and Mrs. Clark K. Sleeth of Morgantown, convention chairman.—Mrs. John E. McKenzie, Press and Publicity.

* * * *

WOOD

The annual dues tea of the Woman's Auxiliary to the Parkersburg Academy of Medicine was held at the home of Dr. and Mrs. William E. Gilmore in Vienna on October 13.

Hostesses for the tea were Mrs. Robert D. Crooks, Mrs. Rex Dauphin, Mrs. Robert K. Fankhauser and Mrs. Gilmore.

Three past presidents, Mrs. Dwight P. Cruikshank, Mrs. Charles F. Whitaker, Jr., and Mrs. Lawrence R. Leeson, and the president elect, Mrs. George E. McCarty, assisted at the serving table.

Mrs. Lyle D. Vincent, the president, and Mrs. Gilmore greeted the guests.

Books Received

THE SPECIALTIES IN GENERAL PRACTICE—By Russell L. Cecil, M. D., Professor of Clinical Medicine, Emeritus, Cornell University Medical College, and Howard F. Conn, M. D., Staff, Uniontown Hospital. Pp. 676. Illustrated. W. B. Saunders Company, Philadelphia, London. 1964. Price $17.50.

* * * *

FITNESS FOR THE WHOLE FAMILY—Paul Dudley White, M. D. and Curtis Mitchell. Pp. 294. Doubleday & Company, Inc., Garden City, New York. 1964. Price $4.95.

Correspondence

644 Weld Street
West Roxbury, Mass.

The West Virginia Medical Journal
Dr. George F. Evans, Editor

Dear Dr. Evans:

It was most kind of you to send a copy of your October issue to me. Since his visit to West Virginia was one of his last ones, this magazine will be especially dear to us all.

It was also very thoughtful to dedicate a special page in his memory.

Sincerely yours,

(Signed) Katherine Welch

FAMILIAR MEDICAL QUOTATIONS
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To the Editor:

A book—*Familiar Medical Quotations*—which we hope will be a great collection of wit and wisdom from and about physicians of the ages is being assembled. The writings and utterances of physicians, teachers and investigators from the dawn of medical history to the present are being sifted for the nuggets of genius and brilliant good humor which characterize the humanity of a profession. The collection will also include quotes from lay writers—including the scriptures—dealing with disease, doctors and medical life.

We are particularly anxious to obtain the quotations of individuals who, unlike Shakespeare and Osler, have hidden their occasional gems so that only a few are aware of them.

We welcome all such favorite quotes that your readers would like to see included in this volume. Contributions may be addressed to me c/o *Familiar Medical Quotations*, 34 Beacon St., Boston, Mass. 02106.

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The West Virginia Medical Journal

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Changing Concepts in Surgical Treatment Of Duodenal Ulcer*

Edward S. Judd, M. D.

AT the present time any proposed treatment for duodenal ulcer must be interpreted in relation to the recent development of the gastric freezing therapy. Wangensteen[1] and his group at the University of Minnesota devised the method and have used it in several hundred cases, developing a large experience with it. In many of these cases, the patient has "spread the good word" to friends troubled with duodenal ulcer so that with the aid of the lay press, the method has become common knowledge. What was a delicate situation at the start is now even more difficult, as patients present themselves requesting that their stomachs be frozen. This has caused redoubling of efforts directed toward determining which patients are indeed suffering from complicated duodenal ulcer.

Wangensteen[2] and his group have been very careful to report the complications which have followed gastric freezing. They have thought that some of these resulted from improper use of the method, but others have developed even in their own cases. Be that as it may, they are continuing to use freezing and extending its application to more and more patients. They are prepared to refreeze the stomach at intervals, even on an outpatient basis.

With regard to this particular facet of the problem, my colleagues and I base our stand primarily on rigidly controlled laboratory experiments which Hallenbeck has carried out in dogs and pigs.[3] The degree of change produced in the experimental animal is startling to say the least. Furthermore, we have seen patients who have presented with gastric ulcer following the "freeze" and patients who have demonstrated rather alarming melena for several days after freezing. Wangensteen's group admits these complications but believes that conservative management of them will suffice. They warn against any gastric surgery for at least 5 days following the freeze, if it is possible to wait that long. The degree of change within the gastric wall makes the local situation most difficult for surgical manipulation. Thus far, because of our own laboratory evidence, we have refused to carry out freezing in the human. Possibly a cautious program will be started under carefully controlled conditions.

With humans, the difficulty is to have a control group and to determine exactly what the results are. After all, thorough medical management in the hospital is enough to relieve most patients without freezing the stomach. We must be very careful to evaluate all of these factors. It seems that if the freezing method proves to be safe enough on extended trial it may develop into an extension of the medical plan for moderately severe duodenal ulcer, with pain relief possibly a logical end-result. Complicated ulcers producing obstruction and significant hemorrhage probably will not be treated by the freezing method.

Surgical Shift

Along more surgical lines, it has been interesting to observe a universal shift away from high

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gastric resection for the control of duodenal ulcer. American surgeons were slow to adopt high resection from their continental contemporaries, but once it started in this country enthusiasm was high. Many surgeons urged an extremely high resection, and it is a matter of record that there was surprisingly uniform control of the ulcer diathesis, but it also is true that postoperatively many patients were gastric cripples. This led us to modify our resection in the intermediate years to include no more than two thirds of the stomach. Concomitantly, the recurrence rate of the ulcer became slightly higher but there was distinctly less gastric crippling. It is to be admitted that once there has been a gastric resection for duodenal ulcer the change is irrevocable. Though modifications in the method of reconstruction are possible, the result leaves something to be desired in many instances.

An interesting apparent trend now is a return to a much more conservative approach. In some parts of the United States this seems to be heading back again to employment of simple gastroenterostomy with no other treatment. When we remember that approximately half of the patients treated thus in earlier days did reasonably well, it is easy to see how the acceptance of this method can be on the rise again, since gastrojejunal ulcer sometimes required as long as 15 years to make its appearance after gastroenterostomy. In this regard it is interesting to review the early proposals concerning vagotomy alone and the problems which follow that operation; but we have learned to respect vagotomy as an integral part among the selected procedures making up the treatment we now employ.

The Occasion for Gastric Resection

Billroth I Operation.—A loyal corps of stalwart enthusiasts continue to extol the virtues of the Billroth I procedure. Certainly many of us are impressed by the low incidence of the dumping syndrome following this operation. Technically, it is the easiest of the gastric resections in most cases, there being no duodenal stump to plague the surgeon, a minimum of suture lines to leak, and no dilemma concerning anterior versus posterior anastomosis or antiperistaltic versus isoperistaltic arrangements.

We were concerned enough about our own material to go into this problem rather exhaustively. Newton[4] and I reviewed the records for a 16-year period ending January 1, 1961. We were struck by the fact that only 244 resections for duodenal ulcer were done by the Billroth I method, which indicated to us that the surgeons were not confident that protection would be adequate. It was found that the hospital mortality was only 0.8 per cent, which certainly was a strong recommendation for the procedure. The overall incidence of complications in the immediate postoperative period was only 14.3 per cent. Weight loss of more than five pounds was detected in 36.6 per cent of our patients, but even this seems to be less than that following the Billroth II operation.

We did find that moderate or severe dumping syndromes were observed in 14 per cent of the patients, which was somewhat more than has been recorded by other surgeons with whose work we are familiar. Most important of all, the incidence of recurrent ulceration (15.1 per cent, made up of 12.2 per cent proved and 2.9 per cent strongly suspected) was significantly higher than any figure quoted by anyone reporting on the Billroth II operation. The amount of stomach removed was reported as approximately two thirds. Vagotomy was not a part of the operation in the overwhelming majority of cases. We concluded from our study that, because of the relatively high incidence of recurrent ulcer alone, the Billroth I gastric resection performed without vagotomy is not the procedure of choice for treating complicated duodenal ulcer.

The University of Washington group under the leadership of Harkins,[5] however, has been enthusiastic about the Billroth I operation for many years. Throughout, they have favored a 70 per cent resection, and they have noted a very low rate of recurrent ulceration, perhaps for this one reason. Then, too, certain surgeons who have combined resection with complete vagotomy have been impressed by the postoperative incidence of severe diarrhea. The need for something better stimulated development of "selective" gastric vagotomy. The rationale is that preservation of that portion of the vagal distribution which supplies the liver, gallbladder, pancreas, small intestine and other structures distal to the stomach should prevent serious diarrhea. Even enthusiasts admit to a much more difficult technical procedure in many instances but they believe that selective gastric vagotomy, properly executed, is just as protective as truncal vagotomy. Several groups of surgeons have reported similar results. Whether the selective method will be universally accepted remains to be seen.

Billroth II Operation.—For many years at this institution some form of the Billroth II operation has been the favorite for dealing with complicated duodenal ulcer. We have agreed that the constant regurgitation of alkaline intestinal content into the gastric remnant has led to a consistently lower rate of recurrent ulceration. We have admitted that an increased number of tech-

nical problems may be the rule and certainly more surgical intervention is required than in the average Billroth I operation. We have felt, however, that the end-result has justified this.

It seemed that combination of vagotomy with a Billroth II type of gastric resection would afford the best possible protection against recurrent ulceration in the ordinary case. But we soon learned that a two-thirds or higher resection, accompanied by vagotomy, still led to a significant degree of the dumping syndrome or at least prolonged chronic malnutrition, and we felt that some compromise was required.

A Fair Compromise?

Having witnessed the results obtained by other surgeons and having followed their work closely, we launched our own studies of hemigastrectomy plus vagotomy, concentrating largely on the Billroth II method. Barber,[6] Stauffer and I recently reported on a series of 235 cases in which the patient was treated in this manner, the series having been terminated at the end of 1961 to allow a significant follow-up period for the majority of patients. It was striking that there was a significant trend over this period, which had begun with 1954. The surgeons were cautious at first, but as results became more apparent they turned to the operation with increasing enthusiasm. We found that the hospital mortality was 1.3 per cent, which we interpreted as a reasonably satisfactory figure. Only 19 of the patients underwent the Billroth I reconstruction; all of the others underwent the Billroth II type with the Hofmeister variation. There were 53 major nonfatal postoperative complications, divided into those not related directly to the gastrointestinal tract (of which pneumonia and wound infection were encountered most frequently) and those related to the gastric operation itself (among which temporary gastric retention and paralytic ileus were observed on occasion).

In view of the considerations mentioned previously, we were especially alert to the development of diarrhea. We concluded that diarrhea of major significance occurred in only 2 cases, in one of which the patient suffered from a rather chronic form of staphylococcal enteritis. Of the 70 cases in which detailed Hollander insulin tests were carried out postoperatively, all but two were reported to be completely satisfactory in regard to the thoroughness of the vagotomy. In our postoperative analysis we found that in 80 per cent of cases the results were "excellent" or "good" but, even more important, to the present time in no case has there been a suspected or proved recurrent ulcer. In the "unsatisfactory" group there were two patients with severe dumping symptoms. Both of these had undergone the Billroth II operation. They later submitted to the Billroth I conversion, and at the time of our analysis both reported that they had experienced great improvement.

The dumping syndrome was indeed witnessed in 24 per cent of the 85 cases with a prolonged follow-up survey, but was severe in only 4 per cent. It was of interest that on reexamination, these patients, although they admitted freely to the symptoms of the dumping syndrome, almost unanimously voluntarily stated that they would far rather put up with these symptoms than go back to their preoperative ulcer state. Regarding weight, 40 of the 80 patients with excellent or good results weighed more than they normally weighed preoperatively. Thirty-seven of 85 patients with prolonged follow-up survey maintained a fairly normal weight but eight others lost significant amounts. Of the five patients with poor or unsatisfactory results, four lost an average of 20 pounds, while one seemed to maintain a rather normal weight.

We concluded from this study that, although a few patients did admit to significant dumping symptoms, the overall picture was encouraging. Since there was no good evidence for any recurrence of the ulcer diathesis, we felt that hemigastrectomy with vagotomy should be continued as perhaps our operation of choice. We are convinced that the vagotomy must be perfect, as missed vagal fibers frequently lead to recurrent ulceration, especially if the resection has been conservative.

Our earlier experience with vagotomy plus gastroenterostomy was discouraging. Although the majority of the patients experienced very satisfactory results in the early postoperative period, prolonged follow-up has disclosed a disturbing rate of ulcer recurrence. Hollander insulin tests in several affected cases have disclosed unsatisfactory vagotomy results, and some patients whose vagotomy seemed satisfactory have redeveloped ulcer difficulty later.

Our Current Plan

In approximately 85 per cent of cases the patient who comes to our institution with duodenal ulcer can be managed successfully by appropriate medical measures. Serious consideration is given to this plan for every patient. If home management up to that point has been haphazard or inconsistent, the patient is urged to come into the hospital for a trial of the medical plan under expert supervision. Those patients who demonstrate that they cannot be productive or lead satisfactory lives on a conservative regimen are considered then for surgical treatment.

This, of course, includes the time-honored indications of hemorrhage, perforation, obstruction, and intractability. Most of our patients nowadays have heard of gastric freezing, and many require a careful interview concerning it.

When we proceed with surgical treatment, we most often employ vagotomy plus hemigastrectomy, frequently completed as a Billroth II operation, perhaps as a holdover from our earlier fears concerning Billroth I reconstruction. We have not found it necessary to be greatly concerned over severe diarrhea in the postoperative period and so to the present writing have not had significant experience with selective gastric vagotomy. The dumping syndrome has been reduced by removing no more than 50 per cent of the stomach. It seems that a few patients exhibit dumping no matter what is done to the stomach in a surgical way, and cases of that kind will continue to be seen. When technical circumstances appear entirely favorable for the Billroth I operation, and especially if the duodenum will lend itself to the performance of a satisfactory anastomosis, we employ that method with little hesitation. If perfect vagotomy is realized we expect the rate of recurrent ulceration to be minimal. We have not been completely convinced that we can eliminate the dumping syndrome even though the Billroth I operation is used.

It now appears that certain earlier enthusiasts for very high gastric resection have turned to a very conservative plan, namely, vagotomy plus pyloroplasty. A small series of these operations has been carried out at our institution, especially in emergency situations. Certainly the surgical interference has been the least possible and should there be later recrudescence of the ulcer problem, a more radical operation can be carried out then. Whether this operation will stand the test of time remains to be seen.

Summary

At present, all types of therapy for duodenal ulcer must be interpreted in the light of current thinking about gastric freezing. Our experience with gastric freezing in laboratory animals has kept us from applying it in humans to date.

There has been a universal shift away from radical gastric resection because of undesirable side effects.

We have proved to our own satisfaction that hemigastrectomy plus vagotomy is accomplished with very low risk, controls the ulcer diathesis completely, and carries a low rate of nutritional problems. The exact method of reconstruction probably is not important so long as the vagotomy is complete.

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Fedicare Is Fedicare

In Latin the verb "medicare" means "to heal." In the newspapers "Medicare" means King-Anderson legislation. In truth the federal government's sponsorship, financing and control, through social security taxes, means federal care or "Fedicare" with a big "FEDI" and a small "care." More and more physicians are discarding the term "Medicare" with its subtle and false implications. Let us suggest that the news media likewise call a spade a spade, and call federal proposals in health care fields by the name which defines them as federal plans and not medical plans.

Communication demands truth, and besides, a rose is a rose and "Fedicare" is "Fedicare."—Robert F. Lorenzen, M. D., in Arizona Medicine.

The Diagnosis and Treatment Of Histaminic Cephalalgia*

Robert E. Ryan, M. D.

On March 30, 1936, at a general staff meeting of the Mayo Clinic, Bayard T. Horton[1] first described what is now called histaminic cephalalgia. He stated that this was a type of headache that had not been described adequately in the literature, that it was a distinct entity in itself, classical in its symptomatology and unique in its response to histamine.

Typical histaminic cephalalgia probably is the most severe of all types of head pain. It is not nearly as frequently encountered as migraines or other types of vascular headache but does appear at nominally frequent intervals. Horton, in his first report, indicated that the majority of his patients were from 40 to 50 years old. Today we claim that the histamine headache patient most commonly is a middle aged male.

According to Horton,[1] the attacks of pain of histaminic cephalalgia are associated with the phenomena of vasodilation; he states that the pathogenesis of the pain lies therein. As proof, he offers the fact that spontaneous attacks can be induced by the subcutaneous injection of 0.3 cc. of histamine diphosphate (2.75 mg. per cc. strength). If the injection is given to a patient with histaminic cephalalgia, a typical headache attack will be precipitated. In a later report he[2] states that when histamine is used as a provocative agent, the immediate (within 5 to 50 minutes) reaction is a generalized histamine headache which is a physiologic response and that the method is useful as a diagnostic procedure.

Terms Not Synonymous

The terms "histaminic cephalalgia" and "histamine headache" are not to be regarded as synonymous. As stated by Horton,[2] when histamine is used as a provocative agent, the immediate reaction is a generalized histamine headache which is a physiologic response. Such reaction will occur in the case of the normal person as well as in that of the individual having histaminic cephalalgia. In the latter instance, however, reproduction of the syndrome will occur approximately 15 to 50 minutes following the histamine headache and the delayed reaction occurs as a pathologic response only in the case of the individual with histaminic cephalalgia.

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Diagnosis Must Be Established

The most vital factor in the management of any headache problem is to establish the diagnosis beyond doubt, for we cannot expect to treat any patient properly unless we have correctly diagnosed his case. In the average headache case, as in practically all disease cases, the most important step in establishing the diagnosis is the careful elicitation of a complete history. This is especially true in cases of vascular headache, in which the physical examination usually will reveal little. It is well to observe the patient's expression and general behavior while he is relating the history of his headache. In order to obtain a complete headache history, the following points should be covered:

1. Full description in patient's own words.
2. Associated manifestations.
3. Nervous tension.
4. What patient means by "headache."
5. Family history.
6. Date headache first occurred.
7. Onset time and cause of onset.
8. Frequency, intensity, character and duration.
9. Location.
10. Scotomata and photophobia.
11. Nausea and vomiting.
12. Sick headache.
13. Rhinorrhea, lacrimation and nasal discharge.
14. Termination.
15. Tenderness.
16. Migratory.

Next comes the examination which may require any or all of the following procedures:

1. General physical examination, including E.E.N.T. and neurological.
2. Routine laboratory tests.
3. X-ray of skull.
4. X-ray of sinuses.
5. Close observation of patient.

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If certain organic lesions are suspected, special diagnostic tests may be indicated.

Symptomatology

While the pain of histaminic cephalalgia is constant in nature, it is of short duration. It lasts only a few minutes on an average but is so excruciating that the patient often is exhausted or fatigued as a result. It is of a burning, boring character and almost always is unilateral. It may involve one side of the head on one occasion and in a subsequent attack the opposite side of the head may be involved. It does not occur on both sides of the head at the same time.

In histaminic cephalalgia there is no vasospastic phenomenon nor aura, and usually there are no pulsations to the pain. In this disease, the time of onset is of more significance than it is in most other forms of headache. The typical attack occurs at night, usually during sleep. The patient is suddenly awakened by the pain, which is of such severity that he is forced to get out of bed immediately. He then usually will pace the floor in a vain attempt to obtain relief. In some cases of histaminic cephalalgia, I have seen the patient ram his head against the floor or the wall because of the extreme severity of the pain. In general, it may be said of histaminic cephalalgia that the pain is far more severe and of far shorter duration than is true of any other type of nocturnal headache. It appears suddenly and leaves as suddenly as it appeared.

No Relativity to Cause

As a usual thing, the histamine headache patient cannot relate the onset of the headache to a definite cause. The attacks are more frequent when he is lying down, and sleeping without a pillow encourages the headache to start. In a few cases he may obtain relief to a minor degree by sitting up but for the most part he must get up and walk about. There are no familiar characteristics connected with histaminic cephalalgia and in the majority of cases no periodic characteristics are exhibited. Most of the attacks occur at irregular intervals, with no set pattern. The pain usually is felt in the area of the temple and the eye; occasionally it is experienced in the face or the neck. The signs and symptoms are limited to the distribution of the carotid arteries.

Vasodilation Phenomena Coincidence

Coincident with the onset of pain in most cases, the patient invariably describes the onset of the phenomena of vasodilation on the same side of the head. The phenomena consist of engorgement of the temporal vessels, injection of the conjunctiva, nasal obstruction caused by plugging of the nasal passage, profuse watering of the eye (lacrimation), rhinorrhea, flushing of the side of the face, and an increase in surface temperature over the eyebrow and in the frontal area.

In those cases in which the patient is a female, there is no association of the menstrual period with the attacks. It should be mentioned here that in the majority of cases of histaminic cephalalgia, the patient is a male.

Many times, pressure applied to the common carotid artery on the involved side will furnish temporary relief. When the pressure is released, however, the pain recurs. Strong pressure over the eye and the temporal vessels will give slight relief in some cases.

Tobacco and Alcohol Influence

It has been found that in most instances there is a relation of alcoholic beverages to exacerbations of pain. The mere abstinence from alcohol, however, will not prevent future attacks although it will cut down on their frequency. While tobacco does not appear to exert any particularly strong effect in these cases, it is better for the patient if he refrains from smoking as a prophylactic measure.

Most histaminic cephalalgia patients sleep with the head propped up with two or three pillows since they know that any position of the body that will cause engorgement of the vessels of the head will cause a marked exacerbation.

Diagnosis

As stated previously, making the diagnosis in the case of a histaminic cephalalgia type of headache depends a lot on obtaining a good history. The problem is somewhat simplified, however, if use is made of the provocative test. When the headache actually is reproduced, it helps to establish a situation in the individual case whereby the physician and the patient have a common understanding of the headache. When such a reproduced attack is aborted, a certain element of confidence is established in the patient's relations with the physician. Such confidence will give the patient a certain degree of freedom from fear and tension. The latter two factors will affect a patient when his attacks of pain have developed to an incapacitating level and all of his many attempts to obtain relief have been of no consequence.

Reproducing the head pain and subsequently aborting the reproduced attack also will give the physician confidence that he will be able to cope with the situation and give the patient the relief

he is seeking. From this comes a patient-physician relation that is desirable in every respect.

Treatment

Treatment in cases of histaminic cephalalgia should be twofold: (1) Alleviation of pain in the present attack (symptomatic treatment) and (2) prevention of subsequent attacks (prophylactic treatment). Failure to attack a headache problem both symptomatically and prophylactically will not bring about the satisfactory results which the patient is seeking, for the average patient does not desire merely relief from his headache attacks but, in addition, a method of preventing them in the future.

We should recognize the physiological stimulus which produces the pain in each individual case and then we should instruct the patient to avoid the stimulus and thus minimize its effects.

We also should always bear in mind that there is no place in the treatment of chronic headache for the use of habit forming drugs.

Prophylactic Treatment

Prophylactically, the use of a vasodilator has been found to be effective in the management of histaminic cephalalgia. The writer's standard method of treatment is histamine desensitization. Histamine, being a vasodilator, will flush out the arterial loop of the localized capillary constriction.

Along with the histamine injections, it often is helpful to give these patients nicotinic acid by mouth, 100 to 200 mg. three times a day before meals. In this respect, it is important not to use nicotinamide, as it is not as effective as a vasodilator as nicotinic acid. For that matter, in so far as the cerebral vessels are concerned, nicotinic acid is not as good a dilator as histamine.[3] These patients actually obtain good results from the use of histamine. They are not cured merely by the power of suggestion, because histaminic cephalalgia is an organic pain of an extremely severe nature and not on any psychogenic basis whatsoever.

I administer the histamine in the intravenous form. The solution I use in such cases is, again, histamine acidphosphate with 2.75 mg. of histamine in 250 cc's. of isotonic solution of sodium chloride. The solution is administered by the drip method for 45 to 60 minutes at a rate of 12 to 16 drops per minute, depending on the rate of flow the individual patient can tolerate. It should be pointed out here that it is best if the patient's stomach is not empty when the intravenous histamine is administered, because it will cause an increase in the gastric secretion of hydrochloric acid. This route of administration is continued for as long as improvement is indicated and until the patient has recovered completely.

It should be stated here that histamine dilates both the intracranial and the extracranial blood vessels. Histamine dilates the arterioles, venules and capillaries. Nicotinic acid produces more vasodilation in the extracranial vessels than it does in the intracranials.[3] It is important that the physician have thorough knowledge of the physiological action of the drugs used in treating an organic condition, and these facts are presented here with this thought in mind.

It is suggested by some that the diet be low in sodium in cases of histaminic cephalalgia, and that the patient abstain from any food or combination of foods that, in the past, may have produced the headache.[4] I have not found diet to be of any great significance in the cases that I have observed and treated, and I believe that it now is generally agreed that neither histaminic cephalalgia nor migraine is on an allergic basis. It also has been suggested that the fluid intake should be reduced in these cases.[4] But, once again, I cannot see where this has any bearing on the physiologic basis of histaminic cephalalgia.

The avoidance of specific allergens by a strict elimination diet on practically a starvation regimen has been recommended.[5] New foods are then added, one at a time, until symptoms of headache are reproduced. The foods which seem to bother the patient are then restricted. The program is continued until all of the allergenic foods are isolated. Here again I state that histaminic cephalalgia is not on an allergic basis physiologically, and I cannot see the value of such a procedure in the treatment of such a patient, either symptomatically or prophylactically.

Symptomatic Treatment

It must be remembered that histaminic cephalalgia represents a distinct clinical entity and is not to be confused with migraine, ophthalmic migraine, or any other type of headache found in man.[6] It seems to represent a localized anaphylactic reaction. Sensitized cells and tissues in the region of the painful area liberate histamine which, in turn, accounts for the localized vasodilation and edema. To this, the symptomatic form of treatment should be directed.

The first preparation to be of any significant value in the aborting of attacks of histaminic cephalalgia was dihydroergotamine. This preparation gives less side effects than ergotamine tartrate which is effective in cases of migraine,

but not as effective in histaminic cephalalgia. Dihydroergotamine, when used in severe cases, should be administered intravenously. I have found in cases of histaminic cephalalgia that the more severe the attack, the quicker dihydroergotamine seems to take effect. In such cases, I have found that the slow injection, intravenously, of 1.00 cc. of dihydroergotamine is most satisfactory. Side effects of this preparation are comparatively low and in most cases the patient shows no toxicity whatever. Some patients will complain of slight nausea or vomiting or general malaise. Occasionally, some experience mild pain in the legs, but this is not too common. The blood pressure does not seem to be affected. Of course, the usual precautions should be observed in advanced cardiovascular disease.

In 1948, an oral preparation was introduced for the aborting of attacks of histaminic cephalalgia. The preparation was experimentally known as E. C.-110, and first reported on by Horton, Ryan and Reynolds,[7] in 1948. This preparation was at first known as Cafergone, but since its introduction to the public the name has been changed to Cafergot. Cafergot contains 1.0 mg. of ergotamine tartrate and 100.0 mg. of caffeine; it is prepared in tablet form. The preparation, to be effective, has to be administered immediately at onset of the attack. I find that the proper dosage of Cafergot is 2 tablets to be taken at the immediate onset of the headache attack. The only toxic effects I have seen when Cafergot has been used are along the gastrointestinal tract. Some patients experience nausea, and a few have mild vomiting attacks.

Several types of rectal suppository have been used in the symptomatic treatment of histaminic cephalalgia. The Pentergot Insert[9] which contains ergotamine tartrate, caffeine, pentobarbital and hyoscyamine sulfate works very effectively in headache problems of this type. The Cafergot P.B. suppository is a product of a similar nature.

These suppositories are in a cocoa butter-like base and require approximately thirty minutes for absorption to take place. The time element led to the Rectalad-Migraine which is a plastic tube with a nozzle type applicator for rectal injection. The rectal tube contains the same types of medication as those found in the tablets and in the suppositories but the medications are in solution and therefore are ready for absorption immediately. This is a great improvement plus the fact that there is no melting problem for the patient to avoid. In normal summer heat the suppositories have to be refrigerated in order to avoid melting.

All patients with histaminic cephalalgia will not respond to the same preparation. The symptomatic treatment, therefore, is a matter of selectivity. Each individual case represents a problem of its own. Thus, the best preparation to use often is found by trial and error. I have merely pointed out the preparations which I personally have found to be most successful in the patients I have treated.

The purpose, of course, of continued research in the field of headache is to find a preparation which will be successful in aborting all headache attacks and one which will produce little or no side effects.[10] Perhaps in the not too distant future this will be found for the patient with histaminic cephalalgia, the most severe of all forms of vascular headache.

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Special Article

Recent Developments in The Federal Government's Narcotic Program

Charles E. Goshen, M. D.

The problem of drug abuse and illegal drug traffic was highlighted by the recent retirement of the Commissioner of the Federal Bureau of Narcotics, ending a 35-year personal crusade against the drug offenders. This period was characterized by an increasingly punitive policy against drug abusers and drug traffickers backed up by a series of federal laws of more and more stringent nature. During this period there also occurred a steady decline in illicit drug traffic, and probably a corresponding decline in narcotic abuse, although there also has been evident a considerable increase in the misuse of non-narcotic drugs.

Considerable dissatisfaction has been expressed at the stringency of the punitive measures currently being employed in the federal program. (The Control Act of 1956 provides mandatory prison sentences without parole). The medical profession, particularly, has challenged the efficacy of these policies in curbing drug abuse. Advocates of the punitive policies generally have been members of the law enforcement professions. A rather bitter controversy has developed in recent years and has stimulated the federal government to reappraise its legislation and drug control program. To this end, the President appointed an *ad hoc* Panel on Drug Abuse to study the question, and called for a White House Conference on Narcotic and Drug Abuse which convened in Washington in September, 1962. The objectives of the Conference were stated to be:

1. To re-examine the whole problem of narcotics use in the United States and to evaluate it in the large context of the abuse of all drugs.
2. To emphasize the lack of firm data in the area of drug abuse.
3. To isolate from fruitless controversy those areas in which there is considerable knowledge from those which require the acquisition of better data.
4. To delineate the role of the various professional segments concerned with the problem.
5. To get all responsible parties to address themselves collectively both to immediate and long term problems.

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The Author

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The Conference

About 600 persons (including the author) were invited to attend the Conference, representing a wide spectrum of professions and agencies. Some of the statements made by panelists and participants are illustrative of the variety of viewpoints and indicative of the need for improved communication and sharing of information:

The President: "I think that there is clear need for, we hope, greater uniformity of opinion by those in this field—medicine, law enforcement, and all the rest—as to the proper method of treatment, how much should be done in hospitals, how much should be done in outpatient treatment, what kind of institutions we need, what kind of medical treatment is most effective. On all these matters, there is such a variety of opinion that I feel this Conference can play a more significant role than most conferences in attempting to assemble in a more unified viewpoint for guidance the varying opinions in the field and the varying suggestions for improvement."

Secretary of the Treasury Dillon: "The Treasury would be the last to suggest that enforcement is the whole solution. The Treasury has opposed the alternative of allowing continued addiction by maintaining drug usage, and this has contributed to some public misunderstanding. In keeping with the viewpoint of the AMA, we have consistently urged treatment and cure. But we have, along with the President's *ad hoc* Panel, joined the very respectable body of authorities opposed to the defeatist alternative of making narcotics legally available to addicts."

Secretary of HEW Celebrezze: "It seems to me that a program of civil commitment for addicts, coupled with a rehabilitative parole system, would give responsible authorities room to exercise professional judgment. This procedure, supported by adequate research, by trained personnel, and sufficient hospital and follow-up facilities, could be an important forward step in meeting the problem."

Governor Brown of California: "Federal legislation should be enacted for the mandatory removal of addicts from society for their treatment with modern and effective techniques and for follow-up close parole supervision on release."

Mayor Wagner of New York: "The social consequences of the narcotics traffic and of narcotics addiction are worse than those of any comparable so-called social evil . . . We must study and learn and establish means whereby the addict, when he has returned from detoxication or from withdrawal or from confinement or shelter, can fit into society; perhaps help to provide a new environment for him and train him for a new job and a new life . . ."

Mr. Giordano, (new Commissioner of the Federal Bureau of Narcotics): "In recent years there has been a substantial amount of criticism directed at the Bureau from a rather insubstantial number of interested persons. Most of this criticism has been founded upon misunderstanding. . . . For several years there has been much misinformation to the effect that the Bureau is interested only in putting the addict in the penitentiary for long periods of time without parole. Nothing could be further from the truth. We do strongly advocate severe penalties for the illicit trafficker whose illegal activities undermine our efforts to keep narcotic drugs away from persons with addiction potentiality."

Los Angeles Chief of Police Parker: "Despite the skilled and intensive efforts of the federal agencies it is estimated that less than 5 per cent of the narcotics smuggled into this country is discovered at the port of entry . . . It is estimated that only one-half of the dangerous drugs manufactured in this country are needed and used for medicinal purposes."

D. C. Chief of Police Murray: "It is felt that some legal means should be developed to enable narcotics officers to stop suspected addicts on the street; to be able to interrogate them; to physically examine them to determine if they are narcotic drug users . . . It is estimated that the average narcotic drug addict comes to the attention of the police in about 2 years (after beginning to take drugs)."

AMA Council on Mental Health Chairman Bartemeier: "I think we all keep in mind that we have a national mental health problem, that these people who become addicted are sick people. Otherwise, why doesn't everyone use narcotic drugs?"

New York Commissioner of Hospitals Trussell: "I must conclude in the light of our experience and scientific knowledge that we have an obligation to provide humane services, to stimulate well designed research programs, to intensify prevention, case finding and aftercare, and to secure a better public understanding that narcotic addiction is like many other chronic diseases for which there is a very low cure rate."

Senator Javits: "For those who accept the premise that addiction is the manifestation of disease and not in itself a crime (and I think this is now overwhelmingly accepted) this is clearly the fundamental scientific basis upon which all other action, both legal and medical, must proceed . . . The federal experience with narcotics hospitals . . . which provide only a period of confinement and isolation and result in a very high rate of recidivation, clearly indicates that some technique other than confinement alone is necessary . . . A program proposed by the Governor of New York . . . includes new hospital construction . . . for periods of confinement for all addicts to achieve detoxication, new clinical facilities for aftercare, and research facilities. Senator Keating and I have introduced a package of bills which would achieve these goals (federal sharing in state programs) and put federally financed tools into the hands of those medically equipped to deal with the problem."

New York Deputy Commissioner of Mental Hygiene Brill: "In the summer of 1958 I made a visit to England (to study the narcotic situation there) . . . in Britain there never has been a large problem in the field of narcotic addiction . . . In the strict sense there is no British system. There are no clinics . . . no official registry . . . no official system of allocation of narcotic drugs. We did find that the problem was really a very small one . . . So, in conclusion, we had to report . . . that the New York State program was not able to find anything in Britain which could be applied in the very extensive program which is being developed here. We found no superior system and no techniques nor results which were particularly different from the techniques and results which are reported from this country."

Tufts University Department of Sociology's Schur: "British narcotics policy . . . is distinctive

in that the entire addiction problem is approached from a primarily medical orientation rather than through stringent law enforcement measures . . . (only) 500 or so addicts are estimated for the whole country. There is no significant addict-crime. No large scale blackmarket has arisen. In Britain, the addict is treated almost entirely as a patient, whereas in the US he has been treated basically as a criminal . . . (British) policies may actually create a climate which is more conducive to treatment success than that which now prevails in the US."

USPHS's Diamond: "The federal hospitals (Lexington and Fort Worth) are 'demonstration projects' for all those who wish to enter this highly challenging field. They demonstrate what must be conducted 'inside' during withdrawal and early physical and psychiatric rehabilitation. Other aspects of the treatment program must be conducted 'outside,' in the patient's homesite, and by the community with its resources."

New York State Division of Parole's Diskind: "The narcotic hospitals are doing an excellent job, but they are handicapped by the lack of a compulsory aftercare system. The final battle must be fought in the community."

National Institute of Mental Health's Felix: "The truth is that narcotic addiction both from the medical and community standpoint is a chronic disease . . . We do not have any medical answers to the problem of narcotic addiction . . . At the same time, however, I believe that at least some of the answers to this grave problem will be found within the community . . ."

New York Medical College Department of Psychiatry's Freedman: "Narcotic addiction is now generally recognized, at least by professionals . . . as a social, medical and psychiatric problem . . . The legislation generally attempts to establish a mental hygiene directed program within a compulsory and punitive context."

American Bar Association's Ploscowe: "The technique which was used basically to meet the post-war increase in drug addiction—this technique of deterrence by terror, of increased prison sentences—this is a beautiful formula, but unfortunately it is unrealizable . . . There was talk about a stream of federal hospitals all over the country to deal with addicts. This would have been a stream of expensive nightmares, in my opinion . . . The Lexington studies have demonstrated that the drug did not have the horrific effect which has been painted in the mythology."

Detroit Department of Health's Raskin: "We are convinced that the addicted person can be helped, but only with an enormous expenditure of energy by the community. The community must become cognizant of the severe emotional sickness and the helplessness of the addicted person."

Federal Bureau of Prisons' Assistant Director, Moeller: "The system of penal sanctions, under which the large majority of narcotic law violators are committed to serve mandatory terms of imprisonment with no provision for probation or parole, accomplishes little other than the temporary incapacitation of the addict . . . The annual outlay (by Federal Bureau of Prisons) for convicted narcotic addicts is estimated to be in excess of $8 million . . . If only economic considerations were involved, the question of alternative solutions to the problem might properly be raised . . . We need a flexible individualized program which gives appropriate weight to medical and mental hygiene considerations."

Senator Dodd: "The problem of drug addiction is essentially a medical problem, a psychiatric problem. It cannot be solved by merciless prison sentences . . . The principal defect in the present law is that it makes no distinction between major narcotic pushers and narcotic addicts themselves . . ."

Senator Keating: "Narcotics addiction is, first of all, a health problem."

US Attorney Morgenthau: "Lengthy hospitalization is no panacea for addiction. The problem of physical withdrawal is a simple one compared to the task of restoring the addict to a useful place in the community. To construct additional hospitals solely for the segregation and treatment of addicts is a serious misuse of the available resources."

Federal Bureau of Prisons' Smith: "The drug addict, I believe, under a broad and properly implemented plan, can be helped and many salvaged . . . Actually the so-called 'addicts' we see are mostly incidental users of low power heroin. Almost never do we now see an addict going through the withdrawal symptoms dramatized on TV or in the movies . . . It is, however, extremely difficult to get this group to participate in our rehabilitation program . . . that, of course, is due largely to the fact that we can provide no incentive for them to better themselves. They are doing a sentence without hope of parole or remission no matter how hard they may try to better themselves (Narcotics Act of 1956 imposes mandatory sentences without provision for probation) . . . The consequence is that when their discharge finally comes many leave little better than when they entered. In fact, some of them may be worse because whatever skill and in-

dustrial contacts they may have had have been lost."

Bureau of Narcotics Counsel DeBaggio: "Several speakers have chosen this occasion to attack existing legislation . . . adopted only 6 years ago. . . . Severe penalties of the 1956 Control Act have been effective. Why should we change them? We are not opposed to treatment. Why change the laws which have been effective so far?"

Report of ad hoc Panel on Drug Abuse: "Many persons who abuse drugs have been generally characterized as inadequate or psychopathic personalities, with a low frustration tolerance . . . They have been described as childishly hedonistic . . . If valid, these observations not only relate to the type of treatment that is likely to be effective, but also emphasize that drug abuse in these cases might better be regarded as an indication of an underlying character disorder, rather than a disease itself . . . Current methods of rehabilitation are not generally adequate."

Comment

The various viewpoints presented at the Conference represent a fairly comprehensive collection of those prevailing in the total area of narcotic control activities in the United States. Certain generalizations can be deduced which could be helpful in clarifying issues and pointing the way toward improved collaboration. These include:

(1) Although there does exist a significant and powerful group who advocate a punitive-police-prison system of dealing with abusers of drugs, their public statements attempt to convey a different impression, claiming to be in accord with medical concepts and pleading for better understanding of their motives and policies.

(2) Many opponents of the punitive policy embodied in current legislation and in the practices of the Federal Bureau of Narcotics advocate changes which sound much like what is now being done, but under different names. For example, some of these people advocate the substitution of "hospitals" for "prisons," "civil committment" for "criminal indictment" and "follow-up care" for "parole." The implementation of these changes, however, is said to require the same type of legal coercion which already has proven to be a serious deterrent to rehabilitation under the current program, and does not seem likely to have an opposite effect through the mere process of changing the labels.

(3) Actually, all viewpoints expressed appear to advocate one of only two possible alternatives: one which sees drug abuse as being primarily a crime, and one which sees the phenomenon as being primarily an illness. It would appear that very little thinking has been done toward the consideration of additional alternatives. Although physicians are prone to regard anything unusual about human beings as manifestation of disease, it would seem that psychiatrists or sociologists would be likely to suggest other possibilities.

(4) Many of the people who are actively working in the field of rehabilitation of drug abusers become confronted with the nagging thought that society in general, and the addict's community in particular, might play a major role in the causation and perpetuation of the drug problem, but they seem loathe to admit its importance. Few, if any, have faced the possibility that Britain's remarkably insignificant drug problem might have something to do with the way in which that society generated a smaller problem than the American society did. Instead, the differences in the two experiences tend to be explained away on the grounds of there being a difference in susceptibility to addiction among the two peoples.

(5) A sizeable number of influential people, including legislators, have come to realize that the mere building of institutions, in itself, is not likely to be productive of improved rehabilitative potentials, even though it is a common error for crusaders to make the mistake of stressing buildings as a solution to social problems. (This error has been made repeatedly in the field of mental hygiene, for instance).

(6) Very little emphasis has been placed on the need to recruit and train the people needed to carry out any new program devised, even though this area represents the most immediate limitation on progress. Surprisingly little awareness of this factor was evident in the conference, yet it could be the most important one to prevent any proposed program from becoming successful.

A Third Alternative

Another way of looking at the problem of drug abuse was hinted at by some participants in the Conference, but not developed into a discrete concept. This way may be conventiently developed as follows:

The excessive nonmedical use of narcotic and similar drugs is—

(1) Something which certain people do (a human activity).

(2) An activity which others regard as unreasonable or *irrational*.

(3) An irrational activity of people who also do many other irrational things in their lives.

(4) Therefore, something done by irrational people.

(5) A phenomenon complicated by the fact that the irrationality of these people is a major obstacle to their rehabilitation and their acceptance by society.

(6) A problem which has much in common with other activities engaged in by irrational people (including alcoholism, compulsive gambling, homosexuality, prostitution, occupational maladjustment, neurotic avoidance of responsibility and reckless driving). The common denominators are that all are self-defeating modes of adjustment which accrue harm primarily to themselves and only secondarily to others (in contrast to the kind of irrational behavior seen in criminals where the harm is done directly to others and for the benefit of the perpetrator).

(7) A problem for which the solution is comparable to that required to solve the other similar types of irrational behavior.

(8) A problem for which the solution is the rather simple one of reeducation which is facilitated when the subject is motivated to make the necessary changes, and impossibly complicated when he is not so motivated. The unwillingness of society to accept the limitation imposed by the uncooperative subject is a principal factor in driving interested persons into untenable theories (such as sickness) in an effort to circumvent this limitation.

Recommendations

The federal and state governments appear to be sufficiently disenchanted by the narcotics control program now in effect to be prepared for the consideration of new approaches. The two opposing theoretical viewpoints which now color the controversy in the field could find many points of agreement in the "third alternative" presented above. A few very general recommendations can be offered as a substitute for, not an addition to, present policies and programs.

It is recommended that:

(1) The function of the Federal Bureau of Narcotics be limited to that field in which it has demonstrated its greatest competence, namely, the international and large scale interstate traffic in drugs, the objective being to confine drug importation, manufacture and sale to ordinary medical purposes.

(2) The Public Health Service divest itself of its two narcotics hospitals and convert them into psychiatric and rehabilitation centers for the Federal Bureau of Prisons, without specific regard to but not to exclude narcotic addiction problems.

(3) The Public Health Service otherwise concern itself with the narcotics problem in the same manner in which it is involved in other health and welfare programs, through financing research and pilot projects.

(4) The Federal Drug Administration exercise the same kind and degree of control over the manufacture and sale of narcotic drugs as is appropriate for it to do in the public interest for all drugs.

(5) At the national and state levels, the problem of the narcotics abuser be treated as part and parcel of a greater problem of social and vocational rehabilitation which needs vastly greater development, reaching out to many groups in need of it.

(6) At the level of public education, steps be taken to initiate and develop a higher degree of sophistication pointed, not toward acceptance of the drug abuser but, rather, toward acceptance of responsibility for rehabilitating him, and for eradicating the social climate which tends to produce the problem.

(7) The medical profession assume a greater degree of responsibility than has recently been the case to curb the widespread excessive administration of drugs (particularly analgesics, sedatives and tranquillizers) to all patients. Furthermore, it is timely for the medical profession to assume more responsibility for the rehabilitation of the individual drug abuser who comes to medical attention.

Conclusion

Current methods of dealing with narcotic addiction at the federal level are in disrepute and widespread controversy prevails concerning possible solutions. Opponents on both sides of the issue tend to err in assuming that there are only two possible viewpoints to choose from. Inadequate distinction is drawn between the issues of drug traffic and drug use. There is, especially, general failure to place the problem in context with other problems of human behavior. A new viewpoint is presented which could help clarify the question.

A Dire Necessity for West Virginia: 'Adequate Minimum Medical Care'*

George R. Callender, Jr., M. D.

This entire presentation must be founded on the premise that the people of West Virginia genuinely feel that the indigent should receive "adequate minimum medical care." To provide this service, the Department of Welfare receives funds from county levies and an appropriation from the Legislature which is matched by federal funds.

It is the responsibility of the Department of Welfare to determine both social and medical eligibility. Clearly defined criteria and an adequate number of well-trained social workers are fundamental to the accurate determination of social eligibility. Similarly, clearly defined criteria and well-documented medical evidence are fundamental to the accurate determination of medical eligibility.

In the past, medical eligibility has been established by the presentation of a statement from the family physician. In some cases the medical evidence is object, well documented and clearly indicates medical eligibility. In some cases the statement of eligibility lacks sufficient objective findings and documentation to justify assistance. In such cases it does not mean that the family physician is incompetent, dishonest or acting in collusion with the patient but, being personally involved with the problems of the family as their physician, may honestly feel the patient is eligible. He also may not have at his disposal necessary x-ray, laboratory or other facilities for proper documentation of disability.

In February, 1962, the Kanawha Medical Society, in cooperation with the Department of Welfare and at their request, initiated a special study which consisted of the examination of men from Kanawha County who were on the Aid to Dependent Children Program because of medical disability. The physicians participating accepted no fee for the services rendered in this special study. Three hundred and twenty-nine patients were examined.

Ninety-six patients had impairment of sufficient magnitude to render them totally disabled. One hundred and six had impairment insufficient to preclude work but sufficient to make it difficult for them to find gainful employment. These men could function in the atmosphere of a sheltered workshop. One hundred and sixteen had insufficient impairment to justify classifying them as disabled.

It became evident that there was a need for the establishment of more clear-cut criteria for the determination of medical disability and a need for a panel or team type of medical review of all potentially eligible recipients of assistance on a medical disability basis.

It is paramount that the Department of Welfare receive sufficient funds to employ an adequate number of well-trained social workers and sufficient funds to continue the Special Study in Kanawha County and extend this type of evaluation to other counties. Failure to appropriate sufficient funds to employ qualified personnel for the proper determination of eligibility will result in far more waste of grant, GMH and MAA money than the amount of money appropriated for personnel employment.

Full-time Medical Director Needed

In 1936 the Public Assistance Act was passed. The revised (1956) Manual of Medical and Hospital Services states, "The Director of Medical and Hospital Services, a licensed physician in the State of West Virginia, under the direction of the Director of the Department of Public Assistance of the State of West Virginia is responsible for establishing such rules, regulations and standards of care as are necessary to insure, within the law and within funds available, adequate minimum medical care to recipients of Assistance. The Director of Medical and Hospital Services will provide technical supervision and direction to the program and will, in general, be concerned with the overall policy, the scope

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of the program, quality and quantity of services that can be provided."

The need for physician directorship of the medical and hospital services of the Department of Welfare was recognized in 1936 on passage of the Public Assistance Act and reaffirmed in 1956. With the additional responsibility of the MAA program for the medically indigent aged to the medical and hospital services, a further need for medical directorship became evident.

Recently there was released for publication the amount of money paid to physicians who received in excess of $5,000 for all services rendered to welfare patients under both the MAA and GMH programs during the 1962-1963 fiscal year. It must be pointed out that these amounts included not only payment for physician services but drugs and supplies necessary for the administration of medical care.

The amount of money paid is under the strict control of the Department of Welfare. If there has been abuse of the welfare program by physicians, it must of necessity be in some form of irregularity in medical practice. Such possible abuse could be determined better by a physician director of medical and hospital services from pay vouchers and personal investigation, than by lay personnel or the press from a simple examination of total payments received.

Physicians located in depressed areas who have rendered service to a large number of welfare patients are already unhappy with the limited medical care programs of the Department of Welfare. These physicians deserve public praise rather than public criticism.

We feel, therefore, that a full-time physician director of medical and hospital services of the Department of Welfare is now more necessary than it was in 1936, 1956 or the last fiscal year!

The medical profession is, of course, interested in accurate determination of social and medical eligibility and genuinely feels that a multi-million dollar medical care program should have the benefit of full-time medical direction. Our background, however, is basically in the rendering of medical care. Any degree of medical care short of the best medical care within our individual capabilities is distasteful to us.

Additional Funds Needed

The West Virginia State Medical Association has repeatedly recommended that the scope of the medical care programs be expanded. An adequate minimum medical care program is considered the very least acceptable to the medical profession. An emergency medical care program is medically inhumane and not financially economical. Incomplete medical care and rehabilitation perpetuates disability and dependency on welfare funds for subsistence.

In the past it has been stated that there were insufficient funds to afford an adequate minimum medical care program. Financial statistics of past years has led to some doubts that this statement has been completely true. Now it apparently is true, at least it is apparent that the amount of appropriated funds for 1963-1964 are insufficient. A deficiency appropriation of $1,500,000 has been requested to operate the MAA and GMH programs through the remainder of this fiscal year.

Sufficient funds to operate the MAA and GMH programs for the 1964-1965 fiscal year must be appropriated to continue even an emergency medical care program. Previous appropriations for the GMH program have been inadequate. The amount appropriated for the MAA program has been more than adequate for the present level of medical care and quite sufficient to improve the scope of the MAA program.

GMH Appropriation Inadequate

Because of the inadequacy of the GMH appropriation, however, the money in excess of that needed for the present MAA program has been used to continue the GMH program. When the physician members of the Joint Conference Committee were asked whether the scope of the MAA program should be expanded, even in the number of days of hospital coverage, instead of using these funds to continue the GMH program, there was no doubt of the answer.

For the purpose of conserving funds, the physician members of the Joint Conference Committee were asked recently which of the chronic diseases should be removed from the approved list. How could we make this decision? The Department of Welfare has had to make such decisions ever since the passage of the Public Assistance Act of 1936. The appropriated funds have only been sufficient for emergency medical care, plus payment of drugs and limited physician services for certain chronic diseases. Patients who just do not happen to have one of these diseases apparently just do not deserve medical assistance.

The failure to supply medical care and drugs in chronic diseases can lead only to continued medical disability and the possible future necessity of acute medical and possible hospital care at considerably greater expense than simple drug administration.

For the sake of humanity and for the sake of economy, funds must be appropriated for an

adequate minimum medical care program. It is far more economical to treat and rehabilitate the indigent sick than support them and their families for the rest of their lives.

Physician Care

Last but not least of the problems confronting the Department of Welfare is physician care. West Virginia physicians have not only been unhappy with the limited scope of medical care. but also the limited fee for services rendered to the recipients of public assistance.

Before going into the dollar and cent problem of the physician we must understand that the patients who fall within the criteria of indigency set by the Department of Welfare and the medically indigent aged who receive some assistance from the Department, are not the only people who are unable or do not pay the physician for services rendered. There are many who fall into the medically indigent group other than those over the age of 65, many who are heads of households and have the problem of medical care for the entire family. There also are many who are quite capable of paying for physician services, but do not.

The physician can, to a certain extent, afford to assume the loss of non-payment of fees for service by treating for nothing those unable to pay in both the medically indigent and true indigent categories, as well as the occasional "dead beat." Because of the necessary overhead associated with the maintenance of his office, the physician can only afford a certain amount of this type of practice and make a living for his family. The individual physician must decide how much.

With the gradual development of depressed areas, a greater percentage of the patients of the doctors in these areas fall into the indigent and medically indigent category. Prior to this time many physicians felt that the time involved in completing the necessary forms was not worth the very small reimbursement received for services rendered to DPW patients and by preference treated them without charge.

The first step was for more and more physicians to bill for services rendered. The MAA program was then initiated and fees were established which covered overhead plus a small amount of compensation for the time spent in the care of the patient. It became financially justifiable and in many cases necessary to bill for all services rendered. The fees for service paid by the Department of Welfare for services rendered by the physician under the GMH program in most instances do not pay the actual cost to the physician exclusive of any compensation for his time.

Prior to the publication of the amount of money received by individual physicians treating welfare patients, there were many who felt that they could not afford to take care of welfare patients but were doing so because of the feeling of responsibility to render service to this group of patients. Following the unjust criticism a number of physicians joined others who, for one reason or another, felt they could not care for welfare patients.

In some communities throughout the State there is a great need for physicians. Many of the communities are in depressed areas. The problem of obtaining physicians in these areas is made almost impossible because of the inadequate compensation for services rendered to welfare recipients. The only logical solution is for the Department of Welfare to pay a reasonable fee for service.

The Association believes that the payment for services rendered under the MAA program of the Department is acceptable compensation at this time for services rendered to the indigent, whether medically indigent or socio-economically indigent. The raising of the fee schedule under the GMH program to match that of the MAA program should solve the problem. It should result in a gradual increase in the number of physicians who would feel they could afford to treat welfare patients. This also should gradually eliminate the necessity of a relatively few physicians caring for so many welfare cases.

Let us set the record straight—this alteration of fee schedules would not make physicians in West Virginia rich. They would still have to obtain greater monetary compensation for treatment from the patient financially able to pay than they would if the Department paid the physician his usual fee for service rendered. The sick who are financially able to pay would still subsidize the care of the indigent sick as far as physician services are concerned.

Would it not be more reasonable for the care of the indigent and medically indigent to be paid from the tax dollar rather than from the pocket of the sick who at that time are least capable of bearing that burden? The failure of the Legislature to appropriate sufficient funds to implement the over-all recommendation of this presentation will perpetuate the many problems of obtaining medical care for the indigent and medically indigent aged of West Virginia. Without these changes little improvement can be expected.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

The President's Page

The Positive Approach of The Medical Profession

In the course of my travels in West Virginia and the neighboring states, I have met and discussed various problems with physicians, members of other professions and vocations, and the general public. I am told repeatedly that organized medicine takes the negative approach most frequently in its attitudes toward the numerous problems that face medicine. They feel this is especially true in the fields of medical economics, legislation and public relations.

It is rather discouraging at times to realize the extent of the impact of the propaganda that has bombarded the American public. This propaganda has originated from the opponents of the private practice of medicine, and the free enterprise system. Their use of the various communications media has been constant and thorough. They would have us believe that the system that has made this Nation great in government, economics, and its various institutions has been outmoded and is no longer useful. We are further told that our ideas of "progress" and our "social consciousness" is remiss. May I refer our critics to the lessons of history down through time, and the basic ideals upon which this republic was founded.

The medical profession does have a positive approach to matters that concern it. May I enumerate a few of the most important precepts and opinions that we advocate.

(1) We are *for* the principles of government as found in the "Constitution," and believe in the dignity and freedom of the individual as expressed in "The Bill of Rights."

(2) We are *dedicated* to the care and treatment of the sick, the prevention of disease processes both organic and functional, and the promotion of medical research and clinical investigation.

(3) We are *for* the protection of both the general public and the profession from all extraneous influences and pressures that interfere with or subvert the above primary functions of the physician.

(4) We are *for* the free practice of medicine, and the free enterprise system generally.

(5) We are *for* the medical and hospital care of the truly indigent patient who needs this care. This is demonstrated daily in physicians' offices, clinics, hospitals and private homes over the Nation.

(6) We are *for* financial help to those truly indigent patients who have become public charges, utilizing the family, local and state units in that order, and with proper safeguards against exploitation.

(7) We are *for* help to any medically indigent older citizen who needs help, and in a manner that maintains his personal dignity, freedom of choice, and freedom from compulsion.

(8) We are *for* pre-paid medical insurance plans that comply with state insurance laws, protect the policy-holders, have board of directors that represent the public, the hospital and medical professions, and that do not represent a promotion by any self-interested segment of the population.

The above statements are a few of the basic things that the medical profession is for, and takes an active part in promoting. We also take justified pride in being against those ideas that are not in the interest of the public, our patients, or the practice of medicine.

It is well to remember that American Medicine has become great as a result of dedication, free competitive spirit, and the pursuit of the goal of excellence.

May I wish all members of the Association a "Happy New Year."

Charles L. Goodhand

Charles L. Goodhand, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

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EDITORIALS

ALEXIS ST. MARTIN COMMEMORATED

The name of Alexis St. Martin, patient of Dr. William Beaumont, surgeon and pioneer physiologist, is known to all physicians, but because of the personality and genius of Beaumont, St. Martin's role has been largely ignored. Beaumont could not have made his contributions to gastric physiology and gastroenterology without the cooperation of Alexis.

It is gratifying that Alexis St. Martin (1794-1880) has at last been commemorated. A Committee of the Canadian Physiological Society in June, 1962, placed a plaque near the place Alexis is buried. It is known that his body was interred on June 28, 1880, in the cemetery of the Roman Catholic church at St. Thomas (near Montreal), Canada, but the exact location of the grave is not known. This has been kept a family secret throughout the years, since it was feared for some time that the body would be unlawfully exhumed.

If a brief digression be permitted, the man who lived so long "with a lid on his stomach" naturally caused considerable interest in the medical profession. No less a personage than Sir William Osler was most anxious to perform an autopsy on Alexis, and especially wished to examine his stomach. He was warned, however, that riflemen guarded the grave by night. Tissue from the corpse probably would not have been satisfactory for study, because the body had been allowed to decompose for several days before interment, and could not be brought into the church for burial service.

The inscription of the plaque reads:

> In Memory of
>
> Alexis Bidigan dit St. Martin
> Born April 18, 1794 at Berthier
> Died June 24, 1880 at St. Thomas
>
> Buried June 28, 1880 in an unmarked grave close by this tablet. Grievously injured by the accidental discharge of a shotgun on June 6, 1822 at Michillimackinac, Michigan, he made a miraculous recovery under the care of Dr. William Beaumont, Surgeon in the United States Army. After his wounds had healed, he was left with an opening into the stomach and became the subject of Dr. Beaumont's pioneering work on the physiology of digestion.
> Through his affliction he served all humanity.
> Erected by the Canadian Physiological Society.[1]
>
> June, 1962

The Committee of Commemoration of Alexis St. Martin also drew up the following enconium:

> In recalling the memory of Alexis St. Martin the Canadian Physiological Society wished to encompass in its tribute all the passive collaborators of science, all the patients who without prospect of immediate benefit contribute nonetheless to the growth and development of science. But most of all the society wishes to pay homage to Alexis, this uneducated man who consented to make the long trips of several months duration in the great canoes, to be separated from his family for years on end, and to

endure who knows how many other forgotten discomforts, in order to be of service to that pioneer of physiology William Beaumont.[1]

It is fitting that the above tribute not only honors Alexis St. Martin, but all those who have, in one way or another, contributed to the growth and development of science by serving as volunteers for scientific investigations. Such services should not be casually accepted in this workaday world, but these volunteers should be highly commended for their eminently worthwhile and unselfish contributions.

1. Alexis St. Martin Commemorated: The Physiologist, 6:63-65, No. 1, (Feb.) 1963.

Should The Patient Be Told The Truth?

Seven years ago a conference was held in Wilmington between physicians and clergymen on the general subject of the relationship of the two professions in their mutual aim toward helping the sick patient. More recently a conference was held where the subject was limited to cancer.

In any such gathering the question invariably arises as to whether or not the patient should be told the truth. The men of the cloth fundamentally believe that humans should be honest in their relationship one with the other. They also teach that in the footsteps of the Great Physician we should be gentle and kind in our approach to patients and that we should obey the Golden Rule. Situations frequently arise where it seems impossible to follow both of these precepts.

The men of the stethoscope are sharply divided. One group believes that it is their duty to inform every patient the complete "truth" about his condition. They believe that the physician should tell the patient who appears to be dying with a malignant tumor that such is the case. There are others who sincerely ascribe to the little white lie as a means of preventing unnecessary mental and emotional anguish in addition to an incurable physical condition.

After all, what is the truth? All physicians, excepting perhaps the recent graduate, have seen patients in whom a diagnosis has been documented of a malignant growth and in whom it is certain that the growth was not removed. Yet, some of these people are living and healthy many years after such a diagnosis.

Some physicians foolishly will inform a patient that he has but so much time to live. How such a physician arrives at any given time has always been a mystery. There are thousands of people living and well years after their physician has been buried, that same physician having told the patient that he had so many months to live. If it is agreed that it is foolish to attempt to quantitate the life expectancy of any individual, isn't it but a small step to also be hesitant to make such a prediction on qualitative grounds? Are we sure that this patient has incurable disease?

Some of these questions are unanswered; some will remain so. Regardless of the difference of opinion in specific instances there is no question but that further meetings between the clergymen and the physician are desirable. Let us leave no stone unturned to see that we are practicing fully and to the best of our ability.—Delaware Medical Journal.

How to Eliminate Undesirable Jargon

The unintelligible and the inhumane types of jargon should be eliminated from medical writing. One wonders whether any other field of literature is quite so badly infected with them. It is possible to find examples of professional cant in other fields; for instance I read that "A librarian was asked to source the material," meaning that the librarian was asked to list the sources from which various statements had been quoted. Or an electrician is said to "fuse a circuit" when he inserts fuses into it. But some fields are remarkably free from jargon. One can hardly imagine a more highly technical field than radio and electronics, but the "Proceedings of the Institute of Radio Engineers," filled with the most technical material imaginable, is quite free from anything that could fairly be called jargon. Engineering publications have set up severe standards for their writers and editors. Strict rules for graphing, for example, have been enforced for at least 30 years. On the basis of their example medical writers should formulate and distribute rules similar to those distributed by engineering societies.

Another possibility would be to establish a Bureau of Semantics or a Council on Neologisms, for guidance in the introduction of needed new words. We need, for example, a shorter word for "neutrophile polymorphonuclear leukocyte." We get into trouble when we add new, arbitrary meanings to old words when a new word would be clearer and more convenient. But we also get into trouble when a new word is introduced without due care. A committee, bureau, or counsel containing at least one good linguist, an authority on practical semantics, and an expert on computing machinery could render invaluable service. They might find that some of the expressions we now consider jargon represent psychologically justifiable developments of our language. Out of place, in serious medical writing, it is bad. In place, it can be convenient and time-saving.—Frederic T. Jung, M. D., in The New Physician.

A Word About 'Profitless Drugs'

The drug industry contributes a great deal more than we have been willing to talk about in the past. We have hidden behind a so-called ethical approach and we got hurt badly. Little mention is made of the profitless drugs that the pharmaceutical industry maintains and keeps today for the health of the nation. How many headlines have we seen about the drug for botulism that Lederle keeps in constant supply to take care of an epidemic—with ten cases recorded in the United States in the year 1962? I have not seen this put in the Congressional Record.—Philip B. Hoffman, Chairman of the Board, Johnson & Johnson, to National Association of Chain Drug Stores, Washington, D. C.

GENERAL NEWS

Tobacco and Health Among Subjects Discussed at AMA Meeting

Dr. Charles A. Hoffman of Huntington served as a member of the Reference Committee on Insurance and Medical Service during the 17th Annual Clinical Meeting of the American Medical Association in Portland, Oregon, December 1-4.

Doctor Hoffman was appointed a member of the Committee on Insurance and Prepayment Plans of the AMA Council on Medical Service during the 16th Clinical Meeting in Los Angeles in November 1962.

Dr. Frank J. Holroyd of Princeton, AMA Delegate and a past president of the State Medical Association, also attended the Clinical Meeting.

Summary of Portland Meeting

The following summary of the Portland meeting was prepared for publication by Dr. F. J. L. Blasingame, Executive Vice President of the American Medical Association:

Tobacco and health, the rights and privileges of Negro physicians, revision of the AMA Constitution and Bylaws, voluntary health agencies and blood banks were among the major subjects acted upon by the House of Delegates during the Clinical Meeting.

The AMA Layman's Citation for Distinguished Service was awarded for the sixth time, and for the first time at a Clinical Meeting, to Mr. M. Lowell Edwards of Santa Ana, California, and Brightwood, Oregon. Mr. Edwards, a 65-year-old retired engineer, has designed and built artificial heart valves now in use in more than 2,600 persons with diseased hearts.

The House at its opening session expressed deep shock at the tragic death of the late President John F. Kennedy and directed that a letter of heartfelt sympathy be sent to Mrs. Kennedy, her children and the late President's family. The House also pledged its support to President Lyndon B. Johnson in forging national unity in the weeks and months ahead and offered the Association's resources, counsel and cooperation on matters of health.

Dr. Edward R. Annis, AMA president, reporting on the recent House Ways and Means Committee hearings on the King-Anderson Bill, told the House:

"The combined testimony of the American Medical Association, the state societies and our allies made a far greater impact on the members of the committee, friend and foe alike, than at any other time in the history of this long and bitter conflict."

Doctor Annis also reported that under questioning from Committee Chairman Wilbur Mills, actuaries of the Department of Health, Education and Welfare admitted that the program of tax-paid hospitalization and related benefits for the aged proposed in the King-Anderson Bill would require a tax rate twice as high as they have previously claimed.

Final registration at the Portland meeting reached a total of 7,103, including 3,144 physicians.

Tobacco and Health

The House approved a Board of Trustees proposal that the American Medical Association Education and Research Foundation undertake a "comprehensive program of research on tobacco and health."

Agreeing that many gaps exist in knowledge about the relationship between smoking and health, the House declared that the study should be "devoted primarily to determining which significant human ailments may be caused or aggravated by smoking, how they may be caused, the particular element or elements in smoke that may be the causal or aggravating agent, and methods for the elimination of such agent."

The action called for procuring a project director "whose experience, qualifications and integrity will assure that such research project will be conducted effectively, exhaustively and with complete objectivity."

The House agreed that the project should be financed by a substantial contribution from the American Medical Association and that contributions should be solicited from other sources—industry, foundations, voluntary health agencies and physicians. It was emphasized that contributions will be accepted only if they are given without restrictions.

Subsequent to the House action, the AMA Board of Trustees voted to contribute $500,000 to help finance the research program.

Negro Physicians

The House considered two proposals related to Negro physicians—a Board report on hospital staff privileges and a resolution concerning membership eligibility in state and county medical societies. The Board report was approved, but the resolution was not adopted.

In adopting the Board report, the House declared that "members of the medical staff of every hospital, where the admission of physicians to hospital staff privileges is subject to restrictive policies and practices based on race, be urged to study this question in the light of prevailing conditions with a view to taking

such steps as they may elect to the end that all men and women professionally and ethically qualified shall be eligible for admission to hospital staff privileges on an equal basis, regardless of race."

In both its approval of the Board report and its rejection of the proposed resolution—which would have denied the rights and privileges of AMA membership to members of any state or county society which refuses membership to any qualified physician because of race, religion or place of national origin—the House reaffirmed 1950 and 1952 policy actions on this subject and directed that a copy of the 1950 resolution again be sent to each state and county medical society. That resolution urged that "constituent and component societies having restrictive membership provisions based on race study this question in the light of prevailing conditions with a view to taking such steps as they may elect to eliminate such restrictive provisions."

AMA Constitution and Bylaws

The House approved comprehensive revisions and rearrangements of the Association's constitution and bylaws as submitted by the Council on Constitution and Bylaws. Among the changes are the following:

1. The Annual and Clinical "Sessions" have been renamed the Annual and Clinical "Conventions."

2. The word "constituent" has been changed to "state."

3. Two types of membership have been created, "Active" and "Special." Active Members are Regular or Service Members. Special Members are Associate, Affiliate and Honorary Members.

4. Affiliate Membership will be available to American physicians engaged in medical missionary and similar educational and philanthropic labors located in possessions of the United States.

5. A quorum will be 100 of the voting members of the House rather than 75.

6. A method has been established to replace a general officer who misses six consecutive meetings of the Board of Trustees.

7. A method has been established for the successor to the President to assume the Office of President if the President dies, resigns or is removed from office.

8. The Board of Trustees has been given express authority to appoint committees.

The House retained present provisions concerning voting on amendments to the constitution but agreed that this matter might be considered by the Committee to Review the Organization of the AMA House of Delegates.

Voluntary Health Agencies

In approving a Board report on professional relationships with voluntary health agencies, the House declared that "the AMA maintain its policy of neither approving nor disapproving national voluntary health agencies." It also agreed "that the AMA, through its Committee on Voluntary Health Agencies, maintain its position of offering guidance on medical aspects of national voluntary health agency programs."

The House approved the "Principles for Medical Guidance to National Voluntary Health Agencies" which contain a new definition of a voluntary health agency, objectives of the Committee on Voluntary Health Agencies and a list of suggested mutual obligations between the AMA and the national voluntary health agencies. The House directed attention to the following two obligations:

"There should be a mutual exchange of information and opinion enabling the medical profession and the agency to understand each other's policy and practice."

"A national voluntary health agency should seek the advice of the medical profession when embarking on a national medical program."

In another action, the House also agreed with a recommendation that the Committee on Voluntary Health Agencies be given the status of a council in the AMA organizational structure.

Blood Banks

The House adopted a policy statement pointing out that in recent years there has been a dramatic growth of blood banking facilities in the United States and declaring that "it is highly essential that the organization of new blood banking programs and the modification of existing ones should have, in the interest of public health and safety, the approval of the county or district medical society and, therefore, should be coordinated with existing approved blood banking facilities." The House also approved a floor amendment stating that since a blood bank can well be considered a medical facility, the top authority in a blood bank should be a physician.

Miscellaneous Actions

In considering a wide varity of reports and resolutions, the House also:

Changed the name of the Council on Scientific Assembly to the Council on Postgraduate Programs;

Extended AMA Affiliate Membership to scientists in sciences allied to medicine;

Changed the name of the Council on Medical Education and Hospitals to the Council on Medical Education;

Approved an amendment to the Bylaws which would permit the opening session of the House of Delegates to be held on Sunday afternoon or evening;

Expressed gratification that the work of the Committee on Medicine and Religion has received widespread acceptance and support from state and county medical societies, religious groups and other related organizations;

Received a report on the AMA Members Retirement Plan and urged physicians to act quickly if they are to exercise their rights under Public Law 87-792 during 1963;

Requested the AMA to seek improvements in the format of its American Medical Directory to make it easier to use;

Asked the Association staff to study the feasibility of opening the Clinical Meeting one week later or two weeks before the Sunday immediately following Thanksgiving Day;

Approved recommendations for criteria on medical examinations for driver limitation under certain specified conditions;

Suggested that an appropriate committee of the AMA work with the United States Public Health Service and industry in providing a type of detergent that will assure safety to the health of the public.

Urged that the term "the aging" be used instead of "the aged" in all statements by the medical profession regarding older persons;

Approved the "Guides for Medical Society Committees on Aging" and recommended their wide distribution and use;

Received a progress report from the Commission on the Cost of Medical Care, which will present its final report in June, 1964;

Agreed that the Committee on Rehabilitation should be reconstituted and that it should include participation of knowledgeable representatives of all related fields of the practice of medicine;

Earnestly recommended that the state medical societies explore the advantages of implementing Kerr-Mills programs in a manner which will permit the care of beneficiaries under voluntary health insurance programs;

Resolved that the AMA attempt to have removed from the Kefauver-Harris Amendment those provisions which authorize the U.S. Food and Drug Administration to determine the effectiveness of drugs;

Reaffirmed the Association's policy of opposing the inclusion of self-employed physicians under Social Security;

Agreed that a short form medical record may be used in cases of a minor nature and, in general, should apply to hospital stays of 48 hours or less;

Approved a Board of Trustees conclusion that the Honors and Scholarship Program, originally proposed in 1960, not be implemented in the light of present circumstances, and

Urged all AMA members to continue to support the Woman's Auxiliary so that it can be successful in increasing its membership, raising more revenue and broadening its range of activities.

Contributions and Tributes

Merck, Sharp and Dohme pharmaceutical company made its third contribution of $100,000 to the student loan fund of the American Medical Association Education and Research Foundation.

The AMA-ERF also received a total of almost $400,000 from physicians in three states for financial aid to medical schools.

The House paid tribute to Mr. Thomas A. Hendricks, who is retiring on December 31, for his 20 years of AMA service.

Doctor Annis was "commended and encouraged in his great work for private enterprise and free American medicine."

By a rising vote of acclamation, the House also expressed appreciation to Dr. Jesse D. Hamer of Phoenix, Arizona, who is retiring after 30 years as a delegate.

Dr. A. C. Esposito Named Chairman Of SMA Section on Ophthalmology

Dr. A. C. Esposito of Huntington was named the first Chairman of the newly created Section on Ophthalmology of the Southern Medical Association during the 57th Annual Meeting, which was held in New Orleans, November 18-21.

In addition to his duties as Chairman of the Section, Doctor Esposito also serves as Councilor from West Virginia to the Executive Committee of the Southern Medical Association.

Another West Virginia physician, Dr. H. Charles Ballou of White Sulphur Springs, was named Vice-Chairman of the Section of Industrial Medicine and Surgery for the coming year.

The Associate Councilors from West Virginia who attended the meeting were Drs. J. C. Huffman of Buckhannon, Nime K. Joseph of Wheeling and H. Charles Ballou. Mrs. Vernon L. Dyer of Petersburg represented the State Auxiliary at the meeting.

Doctor Kampmeier Named President Elect

Dr. R. H. Kampmeier of Nashville, Tennessee, was named president elect of the Association. He will be installed at the 1964 meeting and will succeed Dr. Robert D. Moreton of Fort Worth, Texas, the current president.

Dr. Kampmeier, who is Professor of Medicine at Vanderbilt University School of Medicine, also has served for several years as Editor of the *Southern Medical Journal*. The meeting was attended by a record number of physicians and featured symposiums on "The Relationship of Enzymes and Viruses to Cancer," "Thermal Modalities in Medicine," and "Organ Transplantation."

Doctor Esposito participated as a member of a live television panel discussion on the subject of "Glaucoma."

VA Recruiting Physicians

The Veterans Administration has announced that it is actively recruiting physicians for appointment in the agency's Department of Medicine and Surgery. Dr. George M. Lyon, Director of the Huntington VA Hospital, said physicians in general practice and in almost every medical specialty were needed by the VA nationwide. Starting salaries for physicians range from $8,045 to $14,565, depending on years of training and experience.

Interested physicians may obtain application forms and further information from any VA hospital, or by writing directly to the Personnel Service, Department of Medicine and Surgery, VA Central Office, Washington, D. C., 20420.

Relocation

Dr. Chae Han Chang, who has been a member of the staff of Man Memorial Hospital, has moved to Morgantown where he will serve as Associate Professor of Radiology at the West Virginia University School of Medicine.

Statement by the West Virginia State Medical Association On H.R. 3920 (King-Anderson Bill)

Hearings on H.R. 3920—the King-Anderson bill—were conducted by the House Ways and Means Committee in Washington, Nov. 18-22.

The following statement by the West Virginia State Medical Association, prepared by Dr. D. E. Greeneltch of Wheeling, a past president of the Association, was submitted to the Committee for inclusion in the official records of the hearings:

I should like to take this opportunity to submit for your consideration the views of the West Virginia State Medical Association concerning HR 3920 which we understand will be under study by your Committee starting November 18, 1963.

I am Dr. D. E. Greeneltch, a practicing physician residing in Wheeling, West Virginia. Since August, 1961, I have served a term as President and also as Chairman of the Council of the West Virginia State Medical Association. As a Medical Society officer I have been intimately concerned with the preservation of equitable and adequate health care for the aged citizens of our state. To my knowledge there has not been a single confirmed instance where a person has been denied medical care in West Virginia because of inability to pay.

According to figures supplied by the Research and Planning Division of the Blue Cross Association, the estimated civilian population of West Virginia as of January 1, 1963, was 1,752,154 persons. Of this number 162,950 (9.3%) were 65 years of age or over. Let us consider the various mechanisms under which this aged group received medical care in a state admittedly suffering from a certain degree of economic depression.

The report of the Subcommittee on Health of the Elderly, U. S. Senate, published in October, 1963, states that 26,568 different aged individuals received medical care under the West Virginia MAA program in fiscal 1962 at a combined Federal-State cost of $3,683,418.

The Annual Report of the West Virginia Department of Welfare for fiscal 1962 states there was an average of 17,987 persons on the Old Age Assistance rolls. These individuals are entitled to complete medical care as well as subsistence awards. A sum of $1,471,323 of combined funds was expended in fiscal 1962 to provide medical care under this program.

Thus, in fiscal 1962, a total of 44,555 aged citizens of West Virginia received medical care at a combined Federal-State cost of $5,154,741. It can be assumed that those individuals on OAA received all their medical care under this program since they are a totally indigent group. However, since pre-enrollment is not practiced in the MAA program the 26,568 individuals receiving care under this program must necessarily have been ill in some degree. This would represent a utilization percentage in MAA of 25.9, if we accept an earlier estimate of the Department of Welfare that 102,500 of our senior citizens could qualify.

Contrary to reports that were circulated in 1961 the West Virginia MAA program has never been in financial difficulty. Each year since the inception of this program, in October 1960, there has remained a sizable surplus from funds appropriated by the Legislature. This would indicate that the need for financial assistance by this medically indigent group is being met. There has been a tendency by the Department of Welfare to siphon off excess funds from MAA to implement new welfare programs, instead of constantly working to further improve the scope and effectiveness of this program within the sums appropriated for this purpose.

Since March, 1962, the Joint Conference Committee of the West Virginia State Medical Association has been meeting monthly with the Commissioner of Welfare in an effort to improve both the MAA and other medical programs administered by this department. In addition nine regional medical committees meet with area administrators to adjudicate and settle differences arising between physicians and local offices.

An investigation of the possibilities of insuring eligible clients of the Department of Welfare through Blue Cross-Blue Shield or by independent health insurance carriers is now going on and a progress report will be made to an interim committee of the Legislature later this month.

In late 1962 a panel of physicians from the Kanawha Medical Society worked without remuneration with the cooperation of the Department of Welfare in reviewing the medical eligibility of the Aid to Dependent Children caseload in Kanawha County. This study is continuing and the Commissioner of Welfare has requested funds to form such review panels in all nine welfare divisions of our state. This collaboration must continue.

Up to this point we have been discussing the utilization of existing provisions for providing medical assistance for the aged under the Kerr-Mills Act. We believe it was never the intent of Congress that these programs should supply total medical care to our aged but merely to assist those who need help. We feel that this intent is being realized in West Virginia.

It is the belief of the physicians of West Virginia that voluntary health insurance will expand to cover most of our aged population. The November 4, 1963, issue of Best's Weekly News, a publication of the insurance industry, states that the Insurance Association of America estimates 60 per cent of persons 65 years of age or over were protected by some form of health insurance at the end of 1962. Many new health insurance programs have been introduced since that date. A communication from Blue Cross Association states that 20,898 West Virginians over 65 years of age were covered by Blue Cross-Blue Shield policies on January 1, 1963. Although I do not have the statistics for those senior citizens covered by commercial insurance carriers, my own practice would indicate a greater number of people are insured by these companies than by the Blue plans. The 1962 Statistical Abstract of the United

States indicates 76.8 per cent of all West Virginians carry health insurance. The Health Insurance Institute lists benefits of $56,457,000 paid to West Virginians in 1960. We would remind members of your committee that these figures represent the ability of citizens from an economically depressed state to provide for themselves through voluntary mechanisms. We have been made aware of certain allegations that the individual states do not have sufficient tax revenue to meet available Federal matching funds for carrying on an adequate Kerr-Mills program. It is our contention that if such tax revenue can be made available in West Virginia, an economically depressed state, similar funds should certainly be available in states that are in better financial condition.

In addition to voluntary insurance and welfare programs, a sizable number of our older citizens are provided complete medical care without charge through fraternal organizations, as beneficiaries of the United Mine Workers of America Fund, and as patients in various West Virginia State hospitals (7119 beds) and Veterans Hospitals (1462 beds).

As physicians we are intensely interested in the health and welfare of all our people. We remain unalterably opposed to the enactment of any laws that would finance the health care of all our aged through a compulsory Social Security tax. We consider such legislation unnecessary, ill-conceived and unfair to the lower income group. It is our impression the enactment of HR 3920 would be an irrevocable move. If this bill became law, further expansion in each succeeding Congress would ultimately cover all aspects of medical care with certain deterioration in the quality of this care being the end result.

We appreciate this opportunity to explain the West Virginia story to your committee.

Health Insurance Has Grown 50-Million in 10 Years

Health insurance protects 50 million more Americans today than it did 10 years ago, the Health Insurance Institute reported recently. Ten years ago, only 91 million Americans were covered by hospital expense insurance. Since then there has been an increase of more than one-and-one-half times, and a total of over 141 million persons were protected against the costs of hospital care at year-end 1962.

In 1952, 59 per cent of the U. S. civilian population was protected by some form of health insurance, while at the beginning of this year 76 per cent of Americans were so covered. The same type of growth has been shown by other forms of health insurance.

In 1952, over 72 million Americans had surgical expense insurance, but in the following 10 years there was an 80 per cent increase in coverage and at the end of 1962 over 131 million persons had protection against the cost of surgical bills.

Regular medical expense insurance covered nearly 36 million Americans in 1952. However, there was an increase of more than two-and-one-half times in coverage in ten years so that more than 98 million persons were covered last year.

Dr. Richard W. Corbitt Appointed To Medical Examiner Group

Dr. Richard W. Corbitt of Parkersburg, a member of the Council of the West Virginia State Medical Association, has been appointed by Governor W. W. Barron as a member of the newly created West Virginia Commission on Postmortem Examinations.

Richard W. Corbitt, M. D.

The measure, passed by the West Virginia Legislature March 1, 1963, became law last July 1. It provides for the establishment of a Medical Examiner's System under the supervision of a six-member commission. The Central Laboratory will be located at the West Virginia University Medical Center in Morgantown.

Among the important functions of this system is to ascertain the cause of death when such cause is not obvious. The new law authorizes the appointment of a Chief Medical Examiner, who shall serve as ex officio secretary for the Commission. The Commission also will appoint for each county a medical examiner to serve for a term of three years and until his successor is duly appointed and takes office. All medical examiners shall be qualified physicians, licensed to practice in West Virginia.

Any vacancy in the office of medical examiner shall be filled by the Commission, but in the event of any such vacancy, temporary appointment may be made by the Chief Medical Examiner, to expire upon the appointment by the Commission of an examiner for that county or area.

In addition to Dr. Corbitt, other members of the Commission named by Governor Barron were Oliver C. Eshenaur, D. O., of Pt. Pleasant; State Police Capt. T. A. Welty of South Charleston; Floyd R. Tarr, Weirton Attorney; Lynden S. Fisher, Charleston funeral director, and N. Joe Rahall, Beckley radio and television executive.

New Fellows of ACS

Four West Virginia physicians were inducted as Fellows of the American College of Surgeons during the recent Clinical Congress, which was held in San Francisco. The new Fellows are Drs. I. Braxton Anderson of Beckley, Nicholas W. Fugo of Morgantown, Frank M. Hudson of Wheeling, and James H. Walker of Charleston.

Dr. James E. Boggs Certified

Dr. James E. Boggs of Charleston, who has practiced his specialty of surgery since 1960, was recently certified as a Diplomate by the American Board of Surgery.

Dr. Earl L. Fisher Guest Speaker At Rural Health Conference

Dr. Earl L. Fisher of Gassaway, Chairman of the Committee on Rural Health of the West Virginia State Medical Association, will be a guest speaker at the 17th National Conference on Rural Health in Columbus, Ohio, March 6-7.

Earl L. Fisher, M. D.

Doctor Fisher will present a report on rural health activities in West Virginia on Friday afternoon, March 6, at the Columbus Plaza Motor Hotel.

The two-day meeting, which convenes on Friday at 9:45 A. M., is sponsored by the Council on Rural Health of the American Medical Association.

Cooperating organizations include extension services, farm organizations, Medical Societies and Auxiliaries, health departments, allied health organizations and women's groups.

Discussions will be held on Planning and Action in the Rural Fringe; the Physician, the Clergy and the Patient: Adolescent Health; Rural Health Care—Family Physician, Dentist, Public Health; Health Concerns and Their Improvement; and Quackery in Medicine.

Merck, Sharp & Dohme Program To Assist PG Education

The Merck, Sharp & Dohme Postgraduate Program has been established to facilitate postgraduate medical education. The program supplies funds to medical societies, hospitals, medical schools, educators and physicians for projects that are designed to help the practicing physician keep abreast of the rapid changes and advances in medicine.

The selection of subjects and opportunity remains with the applicant. For specific details, write to the Director of Professional Relations, Merck, Sharp & Dohme, Division of Merck and Company, Inc., West Point, Pennsylvania.

New Teaching Film for Nurses

The importance of good nursing care to a patient recovering from heart attack is stressed in a new American Heart Association teaching film, "Myocardial Infarction: The Nurse's Role."

The 42-minute, black and white sound film follows a patient from the onset of symptoms through the acute stage of his illness, his convalescence and his return home. It may be obtained free of charge from the West Virginia Heart Association, 759 West Washington Street, Charleston, West Virginia.

New Association Members

Dr. Chae Han Chang, WVU Medical Center (Logan). Doctor Chang was born in Seoul, Korea, and received his M. D. degree in 1953 from Severance Medical College in Seoul. He interned at St. Joseph's Hospital in Phoenix, Arizona, 1954-55, and served a residency at the Emory University Hospital in Atlanta, Georgia, 1955-53. He served as a Captain in the Medical Corps of the Republic of Korea Army and was formerly a member of the staff at Man Memorial Hospital. He accepted appointment as Associate Professor of Radiology at the West Virginia University School of Medicine, effective January 1.

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Dr. Chung Sook Chun, Man Memorial Hospital (Logan). Doctor Chun, a native of Hamnam, Korea, received the M. D. degree in 1953 from Severance Medical College in Seoul. Doctor Chun interned at Severance Medical College and the Henrietta Egleston Hospital for Children in Atlanta, Georgia, and served residences at Severance Medical College, St. Louis Children's Hospital and Emory University Hospital in Atlanta, Georgia. Doctor Chun is a Diplomate of the American Board of Pediatrics.

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Dr. Kwan Ho Lee, Logan General Hospital (Logan). Doctor Lee was born in Seoul, Korea, and received his M. D. degree in 1946 from the Medical College of Seoul National University. He interned at Seoul National University Hospital, 1946-47, and served residencies at St. Mary's Hospital in Huntington and Morris Memorial Hospital in Milton, 1953-57. His specialty is orthopedic surgery.

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Dr. Lawrence H. Owsley, Logan General Hospital (Logan). Doctor Owsley, a native of Elmore, Alabama, received his M. D. degree in 1940 from Emory University School of Medicine. He interned and served a residency at the West Baltimore General Hospital in Baltimore, Maryland, 1941-44. He served as a Captain in the Medical Corps of the United States Army, 1944-46, and he previously was located at Boone, Watauga County, North Carolina. His specialty is surgery.

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Dr. Boylston D. Smith, Jr., 150 Park Boulevard, Clarksburg (Harrison). Doctor Smith, a native of Omar, was graduated from West Virginia University and he received his M. D. degree in 1952 from the University of Maryland School of Medicine. He interned at the USPHS Hospital in New Orleans, 1952-53, and then located for practice in Logan. He left Logan in 1957 to take a residency at the University of Maryland Hospital in Baltimore. He served with the United States Army during World War II and his specialty is psychiatry.

Dr. Ray E. Burger Honored

Dr. Ray E. Burger of Welch recently was named president elect of the University of Virginia Medical Alumni Association. He received his M. D. degree in 1937 from the University of Virginia School of Medicine and was an instructor there before opening his practice in Welch.

Tuberculosis Among Leading Causes Of Death in West Virginia

Recent statistics released by the State Department of Health show that tuberculosis has again become a leading cause of death in West Virginia. With 115 deaths from the disease listed for the first seven months of 1963, it now ranks 10th as compared to 13th for 1962. During the same period in 1962 the state recorded 91 deaths—and only 136 for the entire year.

State Director of Health Dr. N. H. Dyer, writing in the department's weekly "State of the State's Health," said that despite the reported efficacy of anti-tuberculosis drugs, the disease is far from being under control.

Doctor Dyer noted the record of failure in the state to effectively reduce the numbers of new cases and deaths. This is how it reads: 1959, 655 new cases, 129 deaths; 1960, 676 new cases, 105 deaths; 1961, 741 new cases, 117 deaths. In 1962, we listed 672 new cases.

He said that in addition "we presently have 3,802 known active cases on our departmental register that require medical management and more than 16,000 on the inactive register that need periodic follow-up and medical evaluation."

Compared to the nation, West Virginia's problem is worse by all known measures: the incidence rate is 36.1 against 29.4; prevalence, 204.4 against 184; mortality, 7.3 against 5.4. In terms of economic impact, it is estimated the tuberculosis problem in the State costs a minimum of $7 million annually—in medical and hospital bills, direct costs to the state for institutionalization, treatment and control measures and losses in productivity.

Doctor Dyer said that in June, 1961, with financial support from a federal grant, the health department launched an intensive control program in four counties of high need which has now been extended to a total of 17 counties.

While evaluation of the project is not complete, he noted that preliminary studies indicate that impressive gains have been made in these areas, primarily as a result of intensified casefinding and application of known techniques of medical management.

Public Health $2.02 Per Capita

In another issue of the weekly publication, Doctor Dyer said that the Health Department is financed by a state appropriation of $1,144,954, or seven-tenths of one cent of each dollar in anticipated general revenue.

He pointed out that of this $1.1 million, direct financial aid to county health units accounts for a total of $450,000, or 39.3 per cent of the entire appropriation. He went on to say that this is money sorely needed by local departments, many of which are hard pressed to provide even a semblance of public health services. But the result is that the State Department of Health now has left approximately four-tenths of one per cent of general revenue to provide a broad spectrum of health services. Also, the demands for direct services from the state level in West Virginia far exceed those expected from most other state health departments because of the inability of many county units to shoulder their portion of the load.

Doctor Dyer noted that if we try to account for all public health expenditures in the state—for monies received from local, state and federal appropriating bodies—the figure approximates $3.76 million. This comes out to about $2.02 per capita—or something less than the cost of a carton of cigarettes or a bottle of patent medicine.

Doctor Klingberg Named Chairman Of New Committee

Dr. W. Gene Klingberg of Morgantown has been named Chairman of the Special Committee on Perinatal Fetal Mortality and Morbidity. He was appointed by Dr. Charles L. Goodhand of Parkersburg, the President.

Doctor Klingberg, Professor and Chairman of the Department of Pediatrics at the WVU School of Medicine, will serve as Chairman during Doctor Goodhand's term of office.

The establishment of the Committee was approved by the Council in November. The Council also directed that the By-Laws be amended to make it a standing committee during the annual meeting at The Greenbrier next August.

The following physicians were named to serve as members of the Committee:

Drs. Robert D. Crooks of Parkersburg, Frederick H. Dobbs of Charleston, Thomas G. Folsom of Huntington, Emma Jane Freeman of Charleston, N. W. Fugo of Morgantown, and Meryleen B. Smith of Peterstown.

Officers and Board Members Elected By W. Va. Nurses Association

Mrs. Josephine Fultz of Clarksburg was elected president of the West Virginia Nurses Association during the 56th Annual Meeting which was held at The Greenbrier in White Sulphur Springs, November 6-8.

Mrs. Fultz will serve a two-year term. Other new officers elected were as follows: Miss Cecilia Coyne of Wheeling, second vice-president; and Mrs. Mabel Strong of Glen Dale, treasurer.

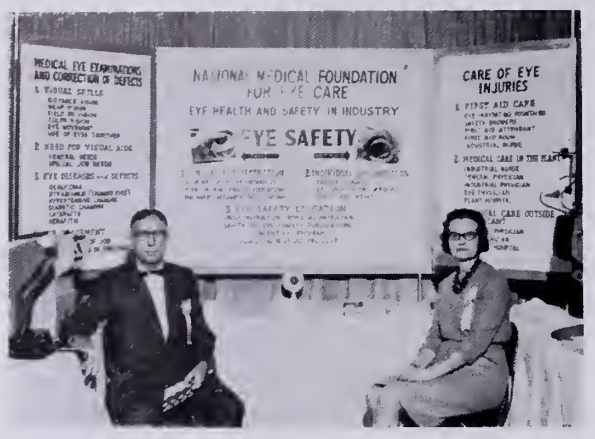
Mrs. Glenice Cather of Grafton and Miss Mary M. Lemons of Beckley were named to the Board of Directors.

Holdover officers are: Sister M. Helen of Huntington, first vice-president; and Mrs. Ardenia M. Tully of South Charleston, secretary.

Medical Meetings, 1964

The following is a partial list of national, state and district medical meetings scheduled for 1964:

Mar. 6-7—National Conf. on Rural Health, Columbus, Ohio.
June 21-25—AMA Annual Meeting, San Francisco.
Aug. 20-22—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Oct. 1—Rural Health Conf., Jackson's Mill.
Nov. 16-19—Southern Medical, Memphis, Tenn.



Dr. and Mrs. Ralph W. Ryan of Morgantown are shown in front of his exhibit on Eye Health and Safety in Industry which was displayed at the recent National Safety Congress in Chicago under the sponsorship of the National Medical Foundation for Eye Care. Doctor Ryan is Chairman of the Foundation's Committee on Training and Registry of Ophthalmic Assistants.

Graduate Medical Assembly Planned In New Orleans, March 2-5

The 27th annual meeting of the New Orleans Graduate Medical Assembly will be held at the Roosevelt Hotel in that city, March 2-5. Dr. I. S. Ravdin of Philadelphia will deliver the Lawson Memorial Lecture and his subject will be "The Future of Surgery." Eighteen other physicians and surgeons will present papers during the four-day meeting.

Further information may be obtained by writing the New Orleans Graduate Medical Assembly, 1430 Tulane Avenue, New Orleans, Louisiana, 70112.

Huntington Woman Named President Of Practical Nurses Assn.

Mrs. Cinda Lou Fowlkes of Huntington was elected president of the Licensed Practical Nurses Association of West Virginia, Inc., at its recent annual meeting in Beckley. She succeeds Mrs. Lenore Guthrie of Charleston.

Other officers named were as follows:

Mrs. Edith Bossie of Dunbar, first vice president; Mrs. Beryl McBee of Morgantown, second vice president; Mrs. Lorraine Suptic of Mount Hope, secretary; Mrs. Surrena Chappel of Charleston, assistant secretary; and Mrs. Nena Hildebrand of Charleston, treasurer.

Southeastern Surgical Congress

The 1964 meeting of the Southeastern Surgical Congress will be held on the S.S. Hanseatic. The cruise will begin on March 21, sailing from Port Everglades (Fort Lauderdale), Florida, returning to the same port on March 28. Stops included will be St. Thomas, San Juan and Nassau.

More than 125 West Virginia physicians are members of the Congress and the Councilor from the State is Dr. Hu C. Myers of Philippi.

Dr. E. Lyle Gage Named Chairman Of Scholarship Study Group

Dr. E. Lyle Gage of Bluefield, a past president of the West Virginia State Medical Association, has been named Chairman of a Special Committee to make a study of the Medical Scholarships Program of the Association.

The appointment was announced last month by Dr. Charles L. Goodhand of Parkersburg, the President. He was authorized by the House of Delegates in August to appoint a Committee to "study the various facets of scholarship loans and grants and to report on the possibility of (1) widening the scope of the present Charles Lively Memorial Scholarship Fund by retaining the rural practice incentive, and (2) working out in detail the administration, cost and other facets of a more extensive loan program sponsored by the State Medical Association, together with its adaptability to our firm intentions of preserving the original concepts of the Charles Lively Memorial Scholarship Fund."

In addition to Doctor Gage, the other physicians named to the Committee are as follows: Drs. Richard V. Lynch, Jr., of Clarksburg, Pat A. Tuckwiller of Charleston, Maynard P. Pride of Morgantown and Richard W. Corbitt of Parkersburg.

The House of Delegates directed that the Committee meet and report back to the Council, with the final report to be made to the House of Delegates during the 1964 annual meeting in August.

Institute on Long-Term Care Facilities In Atlanta, February 24-26

An Institute on Long-Term Care Facilities will be held at the Atlanta-Biltmore Hotel in Atlanta, Georgia, February 24-26. The meeting will be sponsored by the American Medical Association and the American Hospital Association.

The Institute will provide information about planning and design of Long-Term Care Facilities and their relationship to improved patient care. Also featured will be a discussion on techniques of functional and architectural programming of facilities which are intended to serve long-term patients.

Physicians interested in attending the meeting should contact the AMA Division of Environmental Medicine and Medical Services, 535 North Dearborn Street, Chicago, Illinois 60610.

Mrs. Bette Hicks Elected Member Of AAMA Board of Trustees

Mrs. Bette Hicks of St. Albans was elected a member of the Board of Trustees of the American Association of Medical Assistants during the annual meeting of the organization, which was held in Miami Beach, Florida.

Mrs. Hicks, who is a past president of the West Virginia Association of Medical Assistants, was one of several delegates from West Virginia attending the meeting.

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Treatment of Berry Aneurysms of the Carotids And Their Branches*

E. Lyle Gage, M. D.

For many years the outlook for patients with spontaneous subarachnoid and intracerebral hemorrhage was so grim that neurosurgeons welcomed all new knowledge of the cause and possible surgical treatment of the condition. It was only after Egas Moniz's courageous introduction of arteriography, in 1927, that it became clearly understood that the most common cause of these conditions, especially in the absence of hypertension, was rupture of an aneurysm of the brain.[1] With this knowledge and a means of localizing the lesions, surgical attacks upon them have been understaken in real earnest.

Most intracranial aneurysms are congenital in origin. The luetic aneurysms which affect the vessels of the rest of the body are, according to Bucy,[1] practically unknown within the cranial cavity.

Von Bonin[2] pointed out that because of the peculiarity of development of the blood supply to the brain, mistakes happen in that development and they are sometimes given prominence as abnormalities. These happen particularly at the circle of Willis. He noted that the angle at which vessels branch off may change markedly during development. In the early embryo the angle between the anterior and middle cerebral arteries is approximately 30 to 40 degrees. Later in the developmental stages the angle changes so that it is almost 180 degrees. In the angle between the two vessels very frequently the media is missing. Von Bonin further stated that the media of the intracerebral vessels is distinctly less developed than that of vessels of other organs. Furthermore, as the body grows older, the intima of the intracranial vessels begins to split up, and active tissue grows in from the outside. The arteriosclerotic changes go on much in the same way as elsewhere.

The Author

- **E. Lyle Gage, M. D., Head of the Department of Neurosurgery, Bluefield Sanitarium, Bluefield, W. Va.**

Electron Microscopy

Nystrom,[3] using the electron microscope in a study of specimens from 15 patients with aneurysms, found that the walls of arterial aneurysms showed defects of the medial layers and splitting of the elastic lamina. In some cases the elastica was hypertrophied and split up. The elastica was lacking near the sites of the ruptures. Bucy[1] has stated that it is quite correct that many aneurysms develop at the bifurcations of arteries but that there still is another type of aneurysm which is very closely related to embryological development. This type ocurs in small outpouchings of the embryonal vessels which sometimes do not totally disappear but persist after embryological development is complete. Such a vestigial outpouching has been observed on the internal carotid artery just below its bifurcation into the middle and anterior cerebral arteries, and this not infrequently gives rise to an aneurysmal dilatation at that site. Adams[2] has noted that in general the vascular wall is rather thin in proportion to the size of cerebral vessels and that the thinness is due in large measure to the lack of a well developed media.

*Presented before the 11th Annual Medical Seminar of the Bluefield Sanitarium in Bluefield, W. Va., October 3, 1963. Submitted to the Publication Committee, October 28, 1963.

Sex Incidence

Merritt[4] has pointed out that a high percentage of patients with subarachnoid hemorrhage secondary to ruptured aneurysm also have some degree of high blood pressure. He has further stated that defects in the development of the celebral mantle and other parts of the nervous system can be directly traced to failure of development of the blood vessels, and that possibly anoxia may have some effect on the development of cerebral blood vessels, normally or abnormally. According to Merritt, the incidence of subarachnoid hemorrhage, intracerebral hemorrhage and embolism is about equal in the two sexes, and the incidence of subarachnoid hemorrhage has an age distribution similar to that of cerebral embolism, mainly in persons between the ages of 20 and 60 years. No one seems to have any very definite criterion by which to predict impending subarachnoid hemorrhage or rupture of a cerebral artery or aneurysm. In the vast majority of cases, the onset is dramatic and sudden, and the march of events takes place rapidly with headache, nausea and vomiting and, often, coma. Occasionally there are convulsions, which are said to occur in 15 per cent of cases of subarcachnoid hemorrhage. Focal signs which develop in patients with berry aneurysms depend upon the location of the lesion and are no different from those produced by other lesions in the same regions. Aneurysms may become large before they produce symptoms which call attention to them. In fact, they may be large enough to cause focal signs before they leak. Large aneurysms are likely to develop in the intracranial part of the internal carotid artery.[1] The presenting signs of such an aneurysm may vary, but most often have to do with eye findings. The oculomotor nerve most frequently is compressed by an aneurysm. There may be resulting pain in the eye or, with paralysis, there is ptosis, dilatation of the pupil and external strabismus (Figures 1, 2 and 3). The pain of ophthalmic migraine as well as the palsies may be intermittent and recurrent. Large aneurysms which expand into the cavernous sinus will produce ipsilateral exophthalmos by closing off the venous drainage from the orbit.

In this discussion we have considered the arteries from the anterior circle of Willis as branches of the carotids.

Jefferson[4] called attention to the anatomic relation of the circle of Willis to the visual apparatus noting that the optic pathways pass through the circle so that the anterior cerebral arteries are above the optic nerves while the posterior communicating and posterior eerebral arteries are below. When the optic chiasm is pushed upward against unyielding internal carotid artery and anterior cerebral vessels, the lateral and upper surfaces of the optic nerves are compressed and indented by the vessels, producing binasal hemianopsia. Aneurysms of the internal carotid artery and the anterior cerebral may compress the optic chiasm, producing visual field defects which may differ in no way from those caused by pituitary tumor. He[5] also called attention to the pain of trigeminal distribution resulting from aneurysms.

Occasionally plain x-rays of the skull will show shadows of thin plaques of calcium, usually semilunar in shape with the convexity upward, lying beside the sella. These calcifications within the walls of an aneurysm can be differentiated from the dense hyperostosis of meningioma and the flocculent spongy calcification seen above the sella in supraseller cyst. Rather rarely bony erosion of the anterior clinoid process or of the lateral half of the body of the sphenoid and the corresponding portion of the posterior clinoid

Figure 1

Figure 2

process, may result from an aneurysm. The bone is destroyed cleanly.[5]

Types of Treatment

When spontaneous subarachnoid hemorrhage develops, we seek the answer to the site of the hemorrhage by angiography of the carotids. It is believed that better than 80 per cent of these hemorrhages occur in the carotid circuit and that of that number better than 80 per cent can be localized as coming from an aneurysm, with careful or sometimes repeated arteriography. Since we realize that in 50 per cent of cases the victim of an intracranial aneurysm will die within the first year of the first rupture, either as the result of the first or of subsequent bleeding, it behooves us to seek a treatment for the lesion. While angiography is not without its dangers, these are not to be compared with the dangers of delay in treating a ruptured intracranial aneurysm. It is our belief that arteriography should be performed as soon after the diagnosis of subarachnoid hemorrhage is made, as the patient's condition will allow safe conduct to the x-ray room for the percutaneous procedure.

We have continued to use sodium diatrizoate (Hypaque) solution 50 per cent by the percutaneous method except in cases in which poor carotid pulsation or the likelihood of needed carotid ligation indicated the advisability of the open method. Testing for sensitivity to the contrast medium is always carried out. X-rays are made of both carotids in the anteroposterior, the lateral and, occasionally, the oblique positions.

When the diagnosis of aneurysm is made, decision as to the proper treatment must be carefully weighed. The Swedish school led by Olivecrona and his followers, both in the United States and abroad, advocates direct attack upon the aneurysm. Many American neurosurgeons impressed by the remarkable series of cases of Semmes and Murphy, of Memphis, Tennessee, and by those of German, of New Haven, Connecticut, prefer to deal with the aneurysm by ligation of the carotid artery in the neck. It has been our practice to treat aneurysm of the internal carotid, whether in the extracranial or intracranial portion, by ligation of the carotid arteries, particularly if by arteriography or prolonged carotid compression it can be established that there is satisfactory collateral circulation between the two sides of the brain. At first we ligated the artery completely at the operating table under local anesthesia, watching the patient for a period of 30 minutes. In recent years we have been using the slow closure method by

Figure 3

means of the Crutchfield arterial clamp (Figure 4).

Occlusion of the carotid artery in the neck results in immediate definite reduction in the intra-arterial pressure and in the arterial thrust upon the aneurysm in the distal circuit. With an aneurysm at the bifurcation of the internal carotid artery there is a direct jet of blood against the aneurysm and its wall. When the common carotid artery is ligated in the neck the blood reaches the aneurysm through the very circuitous route, and thus the thrust against the aneurysm wall is prevented. By this ligation there is temporary but very marked reduction in distal arterial pressure. There are the loss of jet effect and the loss of the systolic peak.[1] This is excellent treatment for aneurysms of the carotid up to the bifurcation, but not as useful for aneurysms of the anterior or middle cerebral arteries.[1] In two of our cases there developed hemiplegia and massive infarction of the hemisphere following ligation of the common carotid arteries and we have had three deaths from infarction following intracranial clipping of the aneurysm or its artery. Because of these disasters I favor the use of anticoagulants for a few days post-occlusion, as recommended by Bucy[1] and by Gardner and Hamby.[4] Cervical sympathectomy at the time of occlusion of the artery also may be justified.

Our intracranial operations on aneurysms have been performed under general endotracheal anesthesia, most of them with the use of Urevert, and many with the additional removal of cere-

brospinal fluid after the brain has been exposed. We have used hypothermia in only one instance and the operation and the patient's recovery were uneventful. Hamby,[6] in 1962, reported a series of 94 consecutive surgical cases at the Cleveland Clinic with proven ruptured aneurysm of the circle of Willis, with and without the use of hypothermia on a 50-50 basis. He found that hypothermia did not improve the survival rate in these cases of bleeding intracranial aneurysm.

Figure 4

We have used hypotension induced with arphonad only twice. The use of rabbit ear type of removable arterial silver clips for brief, temporary occlusion of the feeding artery to an aneurysm has been of great help in some cases, and placing an umbilical tape about the carotid artery before craniotomy and being able to occlude the artery when the aneurysm ruptured at operation has helped greatly in two cases.

In most of our cases the bilaterial frontal approach has been used but some of the aneurysms of the middle cerebral artery well out in the middle portion have been approached through the Sylvian fissure by means of temporal bone flap. Aneurysms on the posterior communicating artery can be approached either trans-temporally or from beneath the frontal lobe. If, in both of these situations, one can clip the neck of the aneurysm and leave the artery patent, all is well. But if it becomes necessary to obliterate the middle cerebral artery in order to remove or occlude the blood supply of the aneurysm, we feel it best not to deal with the aneurysm by clipping or trapping but to patch it with muscle and fascia and be content, possibly with the additional ligation of the carotid artery in the neck. Before approaching an aneurysm of the left middle cerebral artery it is well, even in left handed persons, to be sure which side of the brain contains the speech center. This can be determined by the slow injection of sodium amytal in the left carotid artery, as described by Rasmussen, and checking for aphasia as paralysis of the right arm is produced.

We recently have operated upon two patients with a more fusiform type of aneurysm of the middle cerebral artery, one of whom had bilateral aneurysm with the right one ruptured into a rather large clot in the right frontal lobe (Figures 5 and 6). In each case we patched the aneurysm with muscle and fascia, and did not ligate either of the carotids. The clot in the frontal lobe was evacuated. Both patients are well and ambulatory at this time. I would not be too optimistic, however, about predictions for their future, only hoping that they live long and free of recurrence.

In some of our cases we have found it necessary to occlude an anterior cerebral artery. One of these on the left side with a clot in the frontal lobe required the occlusion of the anterior communicating artery on that side as well. This patient was hemiplegic for several days, also comatose. Both the coma and the hemiplegia cleared, and at the end of six weeks she was ambulatory and able to talk, but behaved somewhat after the manner of a patient wtih a prefrontal lobotomy. This dull behavior continued for approximately six months before she became her more normal self. Apparently one can usually occlude the anterior cerebral artery on either side, either proximal or distal to the anterior communicating artery, with relative impunity, provided the other anterior cerebral is patent. Aneurysms of the anterior communicating artery sometimes can be trapped between two clips on the anterior cerebral artery nearest the aneurysm, one proximal and one distal to the aneurysm, with a third on the anterior communicating artery on the opposite side of the aneurysm. If this is impossible it may suffice to occlude the principal supplying anterior cerebral artery as determined by the carotid angiography.[1] The following consecutive case reports will serve to illustrate how we have handled some of the problems concerning aneurysm of the carotids and their branches.

An analysis of our 54 consecutive cases of proven berry aneurysm of the carotids and their

branches show the following: There were 27 males and 27 females. Twenty were not surgically treated because of morbid state, poor surgical risk, other systemic disease, multiplicity of lesions or refusal of surgery by the patient or the family. Of this number, six died in the hospital, three reportedly died later, one remained hemiplegic; there is no report on the others concerning death or further hemorrhage.

Occlusion of the carotids by direct ligation or by the slow closure of a Crutchfield clamp was accomplished as follows:

- 2 right and one left internal carotid with no complications.
- 7 right common carotids with one slight dysfunction of the left arm.
- 2 left common carotids with no complications.
- 1 left common carotid with death from edema and infarction of the left hemisphere.
- 1 left common carotid with aphasia and left hemiplegia due to two hemorrhages before the occlusion and with very little improvement after the occlusion but with no more hemorrhages.

Twenty craniotomies were done with the following results: In trapping or clipping of the aneurysm or its supplying artery directly there were 8 with no permanent complications as follows:

- 1 left anterior communicating.
- 1 left anterior cerebral.
- 1 left middle cerebral.
- 1 posterior communicating.
- 2 right anterior cerebral.
- 1 right anterior communicating.
- 1 right middle cerebral artery.

Of the remainder there were three deaths from infarction of the hemisphere and cerebral edema.

- 1 died of hemorrhage from untreated multiple aneurysms.
- 1 died of unexplained recurrent hemorrhage.
- 1 had partial hemiplegia and partial aphasia which persisted.
- 1 had temporary hemiplegia and aphasia which cleared completely.
- 1 died after rupture of the aneurysm at the operating table necessitating carotid ligation and patching. She was believed to have had an infarction of the hemisphere and died three days postoperatively.

Four patients were treated by reinforcement patching of the aneurysm with muscle and fascia. There were no complications in these and none has reported further trouble.

In summary we have presented some of the present concepts concerning the berry aneurysm of the carotids and their branches.

Fifty-four patients were reported upon. Of the twenty non-surgical there were six hospital deaths and three known post-hospital deaths, a rate of 45 per cent; there was one hemiplegia. Of thirty-four surgically treated patients there were eight deaths, a rate of 23.5 per cent; there was one partial aphasia and hemiplegia. The others are still well as far as our knowledge goes. Follow up, however, is not complete.

In our opinion, each case of subarachnoid hemorrhage must be judged more or less on its own merits. If, in a patient with repeated spontaneous subarachnoid hemorrhage, an aneurysm

Figure 5

Figure 6

cannot be demonstrated on the first arteriogram, it may well be worthwhile to do another or even a third arteriogram at subsequent sittings. Aneurysms with good necks that, in our judgment, can be easily clipped are operated upon by the intracranial method. In those cases in which they are more fusiform, patching with muscle and fascia with or without carotid ligation seems indicated. In the aneurysms of the carotid artery proper, occlusion is the method of choice, in our opinion, and that occlusion usually of the common carotid artery. On one occasion the ligation of an internal carotid artery resulted in such accentuation of the thrust into the external carotid that a typical vascular headache of that side of the patients head, similar to migraine, developed.

The use of Urevert, hyperventilation and drainage of the cerebrospinal fluid at the operating table after exposure of the brain have all greatly helped in the handling of these berry aneurysms as has, we believe, the use of bilateral frontal flap and sectioning of the falx cerebri. It is to be hoped that one of the plastics which are now being investigated as a coating will turn out to be the answer to the treatment of aneurysms which cannot be easily trapped. We have not injected any aneurysms with pig bristles, nor have we been impressed with the reports on this technique.

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The Record Speaks

The president-elect of the American Medical Association, Dr. Norman A. Welch, speaking in Portland, Oregon, where the House of Delegates of that vital organization recently met, said that the profession for which he speaks faces the greatest danger in its history. That danger, to sum it up tersely, is the possibility of government domination of the healing arts.

Yet Doctor Welch is optimistic—he feels, for instance, that the Medicare scheme will not ". . . be foisted upon the American people," for the simple reason that the American public at large is against it. Then he told of some of the amazing achievements that can be chalked up to the credit of free medicine as we know it in this country.

In his words, the "dramatic story of the century" is the lengthening of human life—"There are 4.5 million people alive today, who would not have been 25 years ago. For the first time in history life expectancy has exceeded the Biblical three score and ten." He stressed other striking facts—among them that 80 per cent of the drugs commonly prescribed today were not even known 10 years ago, and that this country has developed more new drugs than all the rest of the world combined.

The case against government-dominated medicine, or socialized medicine, or whatever term one wants to apply to it, is overwhelming. In England—a nation more like ours in tradition and attitude, as well as language, than any other—the National Health Service, for all the high hopes held out for it, is in deep trouble. The standards of medical care under socialization have, beyond question, declined, and gravely so. Some believe that the system, whose cost, incidentally, has gone far beyond the original estimates—may ultimately collapse of its own dead weight.

The American medical fraternity, and all those associated with it and related to it in advancing the healing arts, has a record—a hard, factual record—which has no equal anywhere.—The Clarksburg Telegram.

Community Hospital Experience in the Surgical Management of the Elderly Patient

Edward C. Voss, Jr., M. D.

Do you set down your name in the scroll of youth, that are written down old with all the characters of age? Have you not a moist eye? a dry hand? a yellow cheek? a white beard? a decreasing leg? an increasing belly? Is not your voice broken? your wind short? your chin double? your wit single? and every part about you blasted with antiquity? and you will yet call yourself young?—Henry IV. Part II.

Thus was Falstaff chastened by the Lord Chief Justice. Perhaps this rogue justly deserved such analysis, but must we so question our elderly patients that we might consider them too ancient to undergo necessary surgical maneuvers, especially those elective procedures which are well tolerated by them?

Age itself, however, is not necessarily the explanation why patients in the upper age groups often die following surgery. The chief reason is that their disease has been permitted to become irreversible. The elder citizen is mistakenly categorized as being too ancient for the elective hernia repair, the elective cholecystectomy, the elective gastroduodenal surgery.

The older patient need not be subjugated by his chronologic years, with the concomitant problems of wear and tear, but one must consider his physical, physiologic and emotional background in attempting to evaluate the impact of surgical intervention. Interestingly enough, there is a wide latitude of opinion in the literature concerning the significance of age and its associated degenerative processes in determining the surgical results in the aged.

Age Not a Factor

Gilchrist and De Peyster[7] conclude that the patient's age is not the important factor governing operative risk but, rather, the nature and extent of the disease process requiring surgery. Their experience with 390 consecutive private patients, 70 years or older, who had been operated upon for primary disease of the intraperitoneal digestive system tends to support this hypothesis. Stahlgren,[23] in a series of 102 indigent patients over age 69, tends to substantiate this concept, although in a more cautious manner. It long has been the opinion of Mayo that these aged patients, simply by their longevity, have proved themselves to have a strong constitution. On the other hand, Cole[4] feels that concurrent and complicating disease elevated the mortality rate after extensive surgery in elderly patients. Anglem and Bradford[1] believe that physiologic changes in the aged cause a diminution in cardiopulmonary and renal reserve, accounting for an increased mortality rate which in essence attaches great significance to advancing years and associated medical problems.

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The Author

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Errors in Technique and Judgment

The majority of opinion, however, tends to fall in a middle ground, recognizing that the lack of physiologic reserve in the older age groups makes them intolerant of the consequences of errors in technique and judgment. The oft quoted statement that there frequently is little correlation between chronologic and physiologic age forces us to handle these patients as individuals rather than members of an age group.

It is obvious that no simple formula is available which will assure the successful surgical management of the elderly patient. That the problem is recognized is manifest in the large number of papers and textbooks scattered throughout the surgical and medical literature. Several decades past, Rankin and Johnston[21] crystallized our present approach to geriatric surgery, assuring that the nicety of surgical judgment as to when, what and how much to do is the keynote to success in these patients.

Usually, the best procedure for a younger patient also is the best for the older and while meticulous surgery should be common to both groups, the innate inability of older age groups

to tolerate the consequence of error in surgical technique or judgment must be borne in mind. It must be remembered that we are attempting to return these patients to a comfortable and dignified existence rather than rehabilitate a body lacking the spirit. There are circumstances when our enthusiasm must be contained in regard to extensive procedures, when some of lesser magnitude may suffice with much less risk. Efforts to achieve long term "cures" might well be reserved for the younger and more vigorous. The value of staged procedures, as championed by Ziffren,[28] must always be borne in mind.

Finally, while in the younger age groups immediate postoperative success is usually followed by recovery, in the aged patient, statistics related to immediate recovery are less informative and certainly do not give the overall picture, for the consequence of operation upon these patients is difficult to determine and may become quite complex following discharge from the hospital.

Data

In the calendar year 1962, 2993 patients were subjected to major surgical procedures in the Ohio Valley General Hospital, a 450-bed community hospital serving Wheeling, West Virginia, and the surrounding Ohio Valley Basin. Three hundred thirty-eight of these patients were 70 years and older and underwent 346 major procedures, including genito-urinary and orthopedic operations. The great majority were private patients, cared for by various members of the surgical staff. Thirty-eight patients died following surgery. This gives a patient mortality rate of 11 per cent which is certainly meaningless from a statistical point of view, but in overall terms seems to be acceptably low if one cares to contrast this with other series.

As mentioned above, much of the included data would be difficult to compare with the larger series available from teaching centers, yet this report was conceived with the notion of analyzing the morbidity and mortality which might face our elderly patient in his own smaller community hospital. The biblical three score and ten is not chosen as the magic gateway between "advancing age" and senility but, rather, represents the life expectancy of the "average American" of today.

Today's Average Life Span

Statistics of the United States Department of Health, Education and Welfare indicate that the average life span in the United States is now 69.7 years, assessing both sexes. Breaking down such data, however, attests to the "survival superiority" of the American female who now claims 73.0 years of dominance over the male, who is predicted to survive but 66.5 years. These years are a fraction higher when broken down into white groups and considerably lower when broken down into non-whites.

Table 1

Estimated Average Length of Life in the United States

	BOTH SEXES	MALE	FEMALE
1900	47.3	46.3	48.3
1919	54.7	53.5	56.0
1939	63.7	62.1	65.4
1959	69.7	66.5	73.0

Life Tables: Dept. of HEW

All this would seem to be consistent with our present day concepts of greatly improved medical care, which has afforded such a relentless increase in life expectancy, but in reality it must be accepted that this prolonged survival should be attributed to diminished infant mortailty and control of many of the infectious diseases in childhood and youth. For in perusing the tables indicating "Average Remaining Lifetime," it soon becomes obvious that once our elder citizens join the "group," their life expectancy has not materially improved since the turn of the century:

Table 2

Average Number of Years of Life Remaining

WHITE MALE	1900	1919	1939	1959
60	14.35	15.25	15.05	15.6
65	11.51	12.21	12.07	12 7
70	9.03	9.51	9.42	10.1
75	6.84	7.30	7.17	7.9
80	5.10	5.47	5.38	5.9
85	3.81	4.06	4.02	4.5

Life Tables: Dept. of HEW

Statistics for the female are essentially similar except as above they are somewhat more optimistic than in the male.

With these brief data in mind, it must be contended that, within reason, necessary surgery should not be denied a patient because of his age. In dealing with the aged, however, it is always necessary to think in terms of possible life expectancy of the individual. With a less reticent attitude in the indications for surgery, however, perhaps we can effect a more elaborate span of life expectancy in the next few decades. It is obvious that we must so attempt, since projected increases in the age group over 70 suggest that from the record 9,633,000 oldsters in 1959, our geriatric population should "explode" to 15,880,000 by 1980.

Table 3

Surgical Services

Ohio Valley General Hospital—1962

	PAT.	OPER.	DEATHS
Intra abdominal surgery			
Esophagogastroduodenal	10	10	2
Pancreaticobiliary	18	18	1
Small Intestinal	5	5	1
Appendectomy	4	4	0
Colo-rectal	27	31	8
Miscellaneous	3	3	1
	67	71	13
Head and neck surgery	4	4	0
Breast surgery			
Biopsy	1	1	0
Simple mastectomy	6	6	0
Radical mastectomy	5	5	0
	12	12	0
Hernorrhaphy			
Inguinal	27	27	0
Femoral	5	5	0
Ventral	5	5	0
	37	37	0
Vascular surgery	11	11	4
Amputation	12	12	4
Miscellaneous	12	13	2
Total	155	160	23
Orthopedic surgery			
Hip nailing	28	28	5
Hip prosthesis	16	16	3
Miscellaneous	3	3	1
	47	47	9
Urologic surgery			
Suprapubic prostatectomy	14	14	0
T. U. R. prostate	55	56	5
Suprapubic cystostomy	8	8	0
Nephrectomy	1	1	0
T. U. R. bladder	10	11	0
Miscellaneous	4	4	0
	92	94	5
Eye (Cataract Ext.)	23	23	0
Gynecologic surgery	14	14	0
Neurosurgery	6	7	1
E. N. T. (T and A)	1	1	0
Total	183	186	15
General surgery	155	160	23
	338	346	38

In reviewing these 338 cases of patients who underwent surgery on 346 occasions, the associated problems must be oriented. Perhaps Mayo has been correct in the assumption that longevity proves a superior constitution. Slightly more than half of these patients were considered to have obvious historical cardiovascular disease and less than 30 per cent were felt to have severe pulmonary disease, neither of which would seem to be excessive. Only 8 per cent of these patients were felt to be obese and this is significant. Excluding the urologic cases, 56 patients were felt to have serious urinary tract problems and especially in the elderly male this has proved to be a significant problem. One final note may be made concerning the rather high incidence of significant anemia in this group. While one might assume that there is almost invariably some contraction of blood volume in the elderly patient, continued careful attention must be given the fluid compartmentalization. Unfortunately, blood volume determinations were almost a curiosity in this study and even electrolyte profiles preoperatively were none too commonly encountered.

Table 4

Frequency of Co-Existing Disease

	Gen. Surg. (155 pat.)	Ortho. (47)	G.U. (92)	Misc. (44)	Total (338)
Cardiovascular	82	31	52	21	186
Pulmonary	38	12	33	7	90
Urinary	37	15	9	4	65
Cerebrovascular	9	5	3	1	18
Psychiatric	6	8	1	2	17
Obesity	14	3	8	4	29
Diabetes mellitus	7	3	3	7	20
Other malignancy	10	3	6	0	19
Anemia	20	5	7	2	34
Preoperative phlebitis	3	0	1	0	4
Gastrointestinal	4	1	3	2	11
Musculoskeletal	6	4	3	3	16
Metabolic	4	1	2	1	8
Positive serologic reaction	4	2	4	2	12

All surgical conditions must be analyzed as to the urgency of the problem at hand. This, of course, becomes the supreme matter for analysis in the elderly group, since surgery carried out under less than ideal circumstances provokes a high penalty. In our series, very emergent procedures were limited to the general surgical service, and involved intra-abdominal and vascular crises. There may be a fine line of distinction between urgent and emergent in so far as the subspecialties are concerned, yet the urologic patient with acute retention can, in most instances, be converted into a more leisurely problem following adequate bladder decompression. While there is less unanimity of opinion concerning the fractured hip in the elderly, certainly surgery may be deferred temporarily in the face of severe associated problems. The acute abdominal or vascular crisis, however, takes an exacting toll as

might be seen in Table 5-b. Actually, only one patient failed to survive "elective" surgery, which was done for atypical abdominal pain and in whose case no explanation was found at surgery. The second patient, felt to be somewhat elective, actually required surgery for severe ulcerative colitis.

Table 5-a

"Urgency" of Surgical Intervention

	Emergent	Urgent	Semi-Urgent (cancer)	Elective
Gen. Surg.	33	34	44	49
Orthopedics		45		2
Urology		70	15	9
Misc.				
Eye				23
Gyn.	1		6	7
Neuro.	2	2	1	2

Table 5-b

Mortality and "Urgency" of Surgical Intervention

	Emergent	Urgent	Semi-Urgent (cancer)	Elective
Gen. Surg.	9	7	5	2 (1)
Orthopedics		9		
Urology		5		
Neurosurgery		1		

It was not felt justified to overlook the impact found in the surgical specialties, since it becomes obvious in Table 3 that over half of the 346 operative procedures carried out in 1962 involved the subdivisions of general surgery. Further correlation quickly reveals that procedures carried out in orthopedic surgery, urologic surgery and ophthalmologic surgery are somewhat stereotyped and limited in scope. Perhaps we might even say that the mortality arising with these procedures might well correlate with the chronologic and physiologic aging processes in the elderly, as mentioned in the introduction.

In attempting to analyze Table 6 it becomes apparent that the complication rates in general surgical procedures roughly duplicates those in the other group, except for a preponderance of wound and gastrointestinal complications and this, I believe, accounts to a great extent for the discrepancy in the mortality rates. As will be seen in analyzing the mortality data, many of these patients were in a far advanced stage of disease, whether it was benign or malignant. Incidentally, before we pass the term "malignant," it is interesting to note that if we exclude the orthopedic procedures and the cataract extractions, not as large a percentage of malignant problems was encountered as one might expect in these age groups.

Table 6

Postoperative Complications

	Gen. Surg. (155 patients)		Ortho. (47 pat)		Urology (92 pat)		Misc. (44 pat)
Cardiac	7	6*	4	2*	4	3*	0
Pulmonary	9	4*	8	2*	2	1*	1
Urinary	17	10*	9	3*	2	2*	0
Wound	18	3*	3	1*	2	1*	2
Cerebrovascular	6	4*	7	3*	1		2
Gastrointestinal	16	9*	2	2*	1		1
Pulmonary embolism	3	2*	1	1*	4	1*	0
Phlebitis	0		1		2		0
Vascular occlusion	2	2*	0		0		0
Transfusion reaction	1		0		2		0
Parotitis	1	1*	0		0		0
"Sepsis"	0		1	1*	1	1*	0

*Indicates death.

Table 7

Basic Problem in Hospitalization

	Malignant	Nonmalignant
Gen. Surgery	46	109
Orthopedic Surgery	1	46
Urologic Surgery	24	68
Miscellaneous	7	37
	78	260

Twenty-three patients succumbed following intra-abdominal and vascular procedures. Attempts have been made to evaluate these "failures" and this, of course, is difficult since the postmortem percentage could not approximate 100 per cent. In five of these cases it might be said there was an error in technique or judgment. One elderly man sustained an ureteral injury during combined abdominoperineal resection of the rectum and subsequently expired of renal and peri-renal complications. An exceedingly obese woman was intolerant of resection and anastamosis of necrotic colon, strangulated in a recurrent incisional hernia. An elderly man eventually died of sepsis and possibly pulmonary embolization from an axillary dissection carried out in the face of old burn scarring, post radiation change and the operative administration of thiotepa. Two other patients also were felt to have had errors in operative judgment which made for a much longer and complicated procedure, again re-emphasizing the fact that the elder surgical patient is much more intolerant of error in judgment and maneuver than his younger counterpart.

A point to be emphasized is the fact that but two patients died of far advanced, inoperable malignancy. This seems to be an extremely low occurrence in these age groups. To stress the influence of "degeneration" as typified by peripheral vascular disease or its complications, it was found that eight patients had procedures involving the central or peripherial vascular tree.

One tiny lady had thrombosis of the terminal aorta and iliac arteries and expired 48 hours following a most frustrating and unsuccessful exploration. Two patients were lost following abdominal aortic aneurysmectomy and grafting, one done as an emergency. As might be anticipated, renal failure was prominent in both. Finally, extremity amputation terminated in death for the remaining five patients. Two were diabetic, which seems a long survival in diabetic vascular involvement. These patients all had severe cardiorenal and cerebrovascular disease, and amputation might be considered the final scene.

Table 8

Causes of Death

	Principal	Significant Contribution
Cardiac irregularity	1	4
Congestive failure	2	2
Myocardial infarction	2	0
Arterial occlusion	0	1
Cerebrovascular accident	0	1
Pulmonary embolism	5	0
Pneumonia	7	2
Renal failure	7	1
Pyelonephritis	0	2
Shock	1	0
Septicemia	4	0
Peritonitis	5	1
Wound infection	0	3
Evisceration	0	1
Parotitis	0	1
Electrolyte imbalance	0	3
Carcinoma, far advanced	4	0

Consider Patient as a Whole

Interestingly enough, the mortality found in the orthopedic patients was in an older group, 5 of them being in the middle or late 80's. They tended to have rather prominent cardiovascular disease, all save 2 being on digitalis. Three patients were in congestive failure and three demonstrated auricular fibrillation. Two points might be made. These patients all tolerated the operative procedure well. Except for two instances, however, the postoperative course was complicated by sepsis (wound, pneumonitis, urinary tract), so poorly tolerated by the elderly. In fact, as a reminder that the patient as a whole must be considered, one 76-year-old man expired 26 days following fixation of an intertrochanteric fracture sustained in an auto accident. The cause of death was peritonitis due to a perforated duodenal ulcer.

Five patients expired following urologic surgery. Considering that many of these patients were admitted under the urgent circumstance of urinary retention with its associated physiologic derangements, this mortality rate of about 6 per cent does not seem excessive. Only one of these patients succumbed to renal failure. In at least three, however, sepsis was prominent and one man expired abruptly while climbing into bed four days following repeat transurethral resection of the prostate which had originally been performed one month previously. This is mentioned only because a preoperative chest x-ray showed a small area compatible with pulmonary infarction and pneumonitis; yet no activity was manifested in an attempt to minimize the possibility of pulmonary embolization.

Comment

The patient who has survived a multitude of birthdays generally might be assumed to have a significant degree of arteriosclerotic heart disease, with or without clinical manifestations. A history of angina pectoris or previous myocardial infarction, symptoms and signs of congestive failure or the presence of an abnormal electrocardiogram suffice as criteria for diagnosis. Interestingly enough, this did not seem to be borne out in our series, where approximately 50 per cent of the patients were felt to have significant cardiac disease. More significantly, 31 of 38 patients who expired following surgery were felt to have had unquestionable arteriosclerotic heart disease. While the incrimination of myocardial disease as the direct cause of death is at a minimum, the impact of it as a contributing factor must be accepted.

The Elderly Cardiac and Surgery

There are diverse opinions in the medical literature as to the ability of the elderly cardiac patient to withstand surgery, but these opinions do crystallize into two points of focus: the presence of congestive heart failure and a recent myocardial infarction. While we can usually bring the decompensated patient into the realm of a reasonable operative risk within a short period of time, the problem of the recent coronary artery occlusion is more of a problem. Recognition, of course, is paramount, but little can be done about this extreme problem, unless the urgency of the surgery is of such low grade that it can be delayed for 3 to 6 months after occlusion. At this point, elective surgery may be done with little or no increased risk to life, although Hannigan et al[21] found an incidence of postoperative cardiorespiratory complications of 24 per cent following major cancer surgery in 58 such patients, and Nachlas et al[19] experienced a 33 per cent complication rate in 52 patients. No adequate explanation is offered for this increased rate, but meticulous postoperative attention must be given to recognize such problems early since they are not well borne. Reiteration of the extreme care necessary in avoiding hypotension

during anesthesia must be made, although Nachlas could offer no correlation here, for a stable blood pressure offers no guarantee against the possibility of myocardial infarction.

Other than in these categories, skillful anesthesia and well planned and executed surgical operations do not significantly increase the demands upon the heart for work. Patients with organic heart disease who are usually able to tolerate their daily activities without cardiac symptoms do well, assuming that hypoxia and hemorrhage and shock are avoided. Hypertension, cardiac enlargement, valvular disease (excluding aortic stenosis) and electrocardiographic abnormalities *per se* do not increase postoperative morbidity or mortality. "Routine" digitalization is not felt necessary except in those patients with auricular fibrillation or flutter, where it should be carried out regardless of symptomatology or ventricular rate. Interestingly enough, except in those with severe coronary artery disease, postoperative cardiac complications are not particularly common and are seldom responsible for the demise of a patient. While preoperative chest x-rays and electrocardiograms often may seem superfluous, they do serve as an excellent base line in the older surgical patient and often serve as a helpful point of reference in the event of postoperative misadventure.

Cardiorespiratory complications often are lumped together and certainly they frequently inter-relate, yet the pulmonary complications *per se* must maintain their own category, for many of these complications can be correlated rather directly with the intensity of postoperative care afforded the elderly patient. Hypostasis, with its subsequent inflammatory process, has responded to an extent to "mobilizing" the patient. Mucolytic agents are helpful, intermittent positive pressure therapy has its place and the occasional bronchoscopy and tracheotomy may be life saving.

The Polyethylene Catheter

One slight addition to this armamentarium the past year has been the occasional use of a tiny indwelling polyethylene catheter within the trachea, as described by Radigan and King.[20] Its use has been both prophylactic and therapeutic in effecting adequate tracheobronchial toilet. It lacks the obvious distasteful side effects of the tracheostomy and seems to be without significant complication. With increasing use, it would seem to lighten the load for nursing care, in so far as the tracheobronchial tree is concerned, and not as a replacement for tracheostomy.

Four patients were felt to have had preoperative phlebothrombosis, 9 had definite postoperative venous involvement or pulmonary embolization and 5 patients were felt to have expired of massive pulmonary emboli. Much is left to be desired in recognizing, treating and, most significantly, preventing thrombo-embolic disease. Very little data on the actual incidence of this nemesis can be substantiated, yet many authors have shown that, assuming an early diagnosis can be made, prompt treatment of deep venous thrombosis can significantly reduce the death rate from embolization. Yet it is sobering to find that in a group of 595 patients with autopsy-proven pulmonary embolism, Coon[5] was able to uncover a pre-mortem diagnosis of but 7 per cent. This correlates well with similar series.

Blood Flow and Blood Volume

Several factors are inter-related in the flow of blood in the deep veins of the extremities and they have been modified little since Virchow's observations. The cardiac output and associated changes in rate of blood flow, the pressure relations of the thoracic cage itself, the function of the extremity musculature, all are inherent and to some extent correctable. Position in bed is all important, and the extremes of Fowler's position, while recognized as evil, are difficult to prevent, since for some strange notion, nursing care cannot accept that pressure in the pelvic and popliteal areas must be avoided. The pressure of intra-abdominal neoplasm or distention may be severe. Actual blood volume and its compartmentalization are all important, as is the avoidance of dehydration. Attention to these factors can definitely lower the incidence of thrombo-embolic phenomena as has been demonstrated by Murley[18] who lowered the incidence of these complications from 9 to 3 1/3 per cent. A recent innovation by McLachlin and his group[16] stresses the effect of stasis in valve pockets and venous saccules. Using cine radiographic technique, he nicely demonstrated the marked reduction in stasis with a 15 degree elevation of the foot of the table, suggesting that this should be carried out in the operating room and recovery room, as well as the convalescent room. The use of elastic compression altered the stasis insignificantly. Early ambulation is important, but certainly walking for a few moments several times daily has a lilliputian effect on acceleration of venous return.

Thus, in combatting thrombo-embolic complications, the chief emphasis must be placed on the prevention of venous stasis. Little can be done about the anatomic lesions in the vessels

predisposing to thrombosis, and the prophylactic use of femoral vein ligation, while once enjoying not inconsiderable popularity, has rightfully failed to establish its value as a routine matter of prophylaxis. Similarly, prophylactic anticoagulation, especially heparinization, is enticing, although the risk of hemorrhagic complications must be carefully weighed. This has a more rational appeal, however, and in the patient who has a "predisposition" to thrombo-embolic disease, those with a prior history of thrombosis, patients with malignancies, heart disease, prolonged immobility (be it for medical or surgical reasons), possibly patients on prolonged steroids and antibiotics, prohylatic anticoagulation is a valid approach.

The urinary tract in the elderly patient presents several problems. One, of course, is the relative frequency of significant disease of the kidneys and excretory system which exists prior to surgery. As a routine screening procedure freshly voided urine can offer much information, especially if in sufficient quantity of specific gravity. A blood urea nitrogen and creatinine is an excellent screening maneuver, especially the latter. Emergent situations may make the evaluation of urine flow an adequate index. The value of an intravenous pyelogram may be debatable unless pelvic surgery is contemplated, when it should be completely essential.

Perhaps of even greater concern than the preoperative evaluation is the anticipation and handling of postoperative problems, especially bladder dysfunction which is a genuine problem in the elderly male. The rude insult which surgery presents to the man with borderline bladder neck obstruction can be a disaster, particularly in the unfortunate day and age when the indwelling catheter has become such an alarming object, capable of stimulating great bacteriologic upheaval in the genito-urinary tract. It must be remembered, however, that the value of adequate mechanical decompression is also difficult to minimize, and the widespread condemnation of catheters must be carefully weighed.

Attitude

Finally, but by no means least important, comment must be made concerning "attitude," both of surgeon and patient. In no other age group is the surgeon faced with the emotional prospects of finding himself, consciously or unconsciously, as the judge or jury. Often we are faced with the elderly patient, perhaps a little senile, with no social or family life of note, who is completely apathetic towards further survival. Here comes into play the delicate interplay of the science of medicine and the art of medicine. Scientifically, our problems are clear cut, but morally and philosophically they are not. This, of course, is a more soluble problem in the patient with advanced neoplastic disease; in the patient with benign disease, however, especially presenting as a complicated emergency, much mental turmoil is often brought about. These are the factors that cannot appear on charts. They defy statistical analysis, but in reality account for a goodly portion of our postoperative problems, morbidity and mortality. In essence, we must apply our art and science not only to save life, but to add life to years as well as years to life.

Summary

These data were accumulated, not to supplement the large series emanating from teaching centers or indigent hospitals, but to contrast the care of the elder citizen in his own community hospital, not necessarily undergoing dramatic surgery, but the surgical problems inherent to his age group. A most significant factor which cannot appear in the statistics, of course, is the "delayed complication." Several personal patients included in this paper tolerated hospitalization quite well, only to expire at home several weeks or months later of a cerebrovascular insult or pneumonitis. Just how great an impact surgery has on these patients cannot be accurately stated. Yet the possible correlation with future problems and complications must always be borne in mind when statistics are applied to an elderly hospital population.

Finally, adding necessary repetition, "geriatric surgery" has come into its own. With somewhat more meticulous attention to detail, the older patient usually tolerates major surgery quite well. In addition, with broadening of the horizons in the indications for surgery, many patients will be spared the undesirable risk of emergent surgery.

A list of references may be obtained by writing the author.

Special Article

Dr. Jesse Bennett – Pioneer Physician*
(1769-1842)

Mrs. Melinda Hamilton

A seldom noticed marker along State Route 62 two miles north of Point Pleasant commemorates Mason County's role in the first caesarean birth in the United States. The marker stands as a tribute to Dr. Jesse Bennett who performed this first caesarean section for his young wife, Elizabeth, under almost unbelievably crude conditions.

The story began in colonial Virginia in the early 1790's . . .

A young Philadelphia doctor rode through the hills of Virginia early in the spring of 1793. In the valley below him he could see the rolling plantation owned by Major Peter Hogg. Its slave quarters stood in neat rows and the formal gardens looked much like a picture etched into the rough landscape.

Perhaps it was this day that Dr. Jesse Bennett asked Major Hogg's daughter, Elizabeth, to be his wife. He had known her for over a year and visited the Hogg family home frequently.

Elizabeth was a small woman with dark hair. Her father had graduated from Edinburgh University and Elizabeth was nearly as well educated has her father. She was every inch a Virginia lady.

In April, Doctor Bennett took Elizabeth home, as his wife, to the white frame house. Doctor Bennett owned about ten slaves and had a comfortable income. If there was ever a lack of money in the Bennett home it was due to the fact that Doctor Bennett often treated slaves and others who couldn't afford to pay him, only accepting a basket of barley or their thanks for his services.

But in the spring of 1793 Virginia never seemed more beautiful to Doctor Bennett and his wife as the earth bloomed before their eyes. Soon after they were married Elizabeth became pregnant with their first child. Summer turned to fall and fall to winter.

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The Author

- **Mrs. Melinda Hamilton, Staff Reporter, The Point Pleasant Register, Point Pleasant, W. Va.**

Doctor Bennett engaged Dr. Alexander Humphreys of Staunton, Virginia, to deliver the baby. Doctor Humphreys arrived on schedule as Elizabeth began her painful, however, historic birth.

Doctor Bennett stayed close to his wife as the winter day drew to a close and the baby couldn't be born. Even forceps couldn't aid the delivery.

The only light in the room was an oil lamp held by a faithful negro slave. The light fell on the woman Doctor Humphreys felt sure could never deliver the child. Doctor Humphreys thought death was inevitable . . . for both the mother and child.

During the night Elizabeth begged to have the child saved even at the cost of her own life. Finally the clock struck midnight and Doctor Humphreys walked from the room a tired and defeated man.

Doctor Bennett, determined to save both the child and his wife, asked Doctor Humphreys to assist him in an operation he had read of. The operation was a caesarean section birth . . . an operation never before performed in the United States.

Doctor Humphreys refused to assist, feeling that at any rate the operation would be murder for both mother and infant.

Doctor Bennett called two slaves to the house. They gathered two barrels and large planks. From these crude materials, Doctor Bennett made an operating table. His instruments were crude and improvised. His anesthetic was a herb called laudanum which does not kill pain but merely induces sleep.

The slaves brought Mrs. Bennett from the bedroom to the table. Her sister, Mrs. Hawkins, held the lamp for the light which guided Doctor

Bennett's hand. And thus in the early morning hours of January 14, 1794, Doctor Bennett performed the first caesarean operation in the United States.

For the stitches Doctor Bennett used only clean white linen thread comparable to that used in heavy sewing. Both the mother and baby girl, Maria, recovered quickly. Doctor Bennett's records show that Elizabeth was pronounced completely recovered by early March.

When Maria was two or three years old, the Bennetts moved to Mason County on a tract of land given them by Elizabeth's father, Major Hogg. He had acquired it earlier in a generous grant from the King of England.

Here, in the Ohio Valley, Doctor Bennett set up his practice. He grew to such importance in the area that Aaron Burr and Harman Blennerhassett asked for his help in their ambitious plan to overthrow the government. Doctor Bennett refused their scheme, living as a leader in the Ohio Valley until his death in 1842 at the age of 73.

Elizabeth preceeded her husband in death in 1830, 36 years after the birth of Maria, who lived to be 80.

Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

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Special Article

The Matrix of Life*

W. D. Snively, Jr., M. D.

General awareness that humans possess an internal body fluid undoubtedly goes back to the dawn of history. The ancient Hebrews had a saying, "The causes of all diseases are to be found in the blood." The Bible contains many references to body fluid and related matters i. e., blood, serum, perspiration, breathing, fever, diarrhea, protein, salt, the kidneys, puffy eyelids, to mention a few.

It was Galen, a Greek, and a practitioner of medicine in Rome during the Second Century, A. D., who first established the fact that blood vessels were filled with a liquid and not with gas. He knew of insensible perspiration, recognized the lacteal vessels which carry lymph. Amazing discoveries were made over the centuries by untutored persons. Convicts sentenced to lashing to the point of unconsciousness learned how to produce a carbonic acid deficit and unconsciousness simply by overbreathing.

Jonathan Swift, in "Gulliver's Travels," makes some modern sounding statements about dietary salt: "I was at first at a great Loss for Salt; but Custom soon reconciled the Want of it; and I am confident that the frequent Use of Salt among us is an Effect of Luxury, and was first introduced only as a Provocative to Drink; except where it is necessary for preserving of Flesh in long Voyages, or in Places remote from great Markets. For we observe no Animal to be fond of it but Man: And as to myself, when I left this Country, it was a great while before I could endure the Taste of it in any thing that I eat." Those of us who have been on low sodium diets can attest to the correctness of his observations.

Our body fluid is, in reality, the chemical matrix of life. Our extremely remote ancestors brought it with them when they said farewell to their ocean home eons ago and gingerly, we can be sure, came ashore to enjoy their Paleozoic Palm Beach, as Gamble charmingly called that first landfall.

*Presented before the annual meeting of the West Virginia Chapter, AAGP, in Charleston, May 26, 1963.
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The Author

- **W. D. Snively, Jr., M. D., Evansville, Indiana, Executive Vice President of Mead Johnson & Company.**

Each of us contains within his body a tight little pond that ages ago was part of the vast blue ocean. That pond, which we call body fluid, represents man's link with his aquatic past. I am going to talk to you about the body organ which makes it possible for man to walk about on dry land, a fugitive, as it were, from his ancestral ocean. That organ is, of course, the human kidney.

Human body fluid makes up 60 per cent to 70 per cent of the body weight. This means that a man of 150 pounds would have about 90 pounds of body fluid. Approximately two-thirds of it is contained within the cells, so we call it the cellular fluid. About one-third surrounds and bathes the cells, and we call it the extracellular fluid. One-fourth of the extracellular fluid is confined within the blood vessels as plasma. Three-fourths is outside the blood vessels as interstitial fluid. Although the extracellular fluid is only about one-third of the total body fluid, it is the circulating, dynamic portion of this fluid. It is into the extracellular fluid that injected parenterals pass, and it is extracellular fluid that is withdrawn when the blood level of a given drug is tested.

If one is to remain healthy, the volume and the chemical composition of his extracellular fluid must be maintained within a narrow corridor of normal. Yet the difficulties involved in maintaining constant the composition of the extracellular fluid stagger the imagination.

Consider the billions of cells of the body constantly pouring the results of chemical reactions into the extracellular fluid, constantly withdrawing from it substances needed for specific organ or cellular activities. We eat and drink a wide

variety of materials which by no means are matched with body needs. Some of the materials contain many times the electrolyte content of the extracellular fluid. Some of them contain substances which could be poisonous unless they were quickly excreted. In short, our digestive tract is sublimely nonselective. With total lack of discrimination it absorbs practically everything offered to it. All's grist that enters its mill. The volume of liquids we drink might quickly drown us were there no mechanism for maintaining the volume of the extracellular fluid constant. These are the problems in health. They are multiplied many times in disease, which adds to the already herculean task of maintaining constant the volume and chemical composition of the extracellular fluid.

Organs of Body Automation

Fortunately, nature also has provided each of us with a set of automatic controls, a system, if you will, of body automation which both executes and demonstrates the wisdom of the body. Interestingly enough, the system utilizes some of the very principles that are incorporated in man-made automation systems. One is the principle of feedback. In other respects, however, body automation departs strangely from the precepts of automation. It sometimes utilizes principles that no engineer in his right mind would incorporate in an automation system. Yet, in its efficient handling of an unbelievably complex task, body automation puts man-made automation to shame.

What are the chief organs of the body that maintain constant the chemical composition of the extracellular fluid? Largely, the responsibility for regulation falls upon the kidneys, the adrenal glands, the parathyroid glands and the pituitary gland.

We designate these as the organs of body automation. There are many other organs and systems throughout the body that participate in the important task of preserving chemical balance in the extracellular fluid, but the four mentioned are really the key units.

Since the kidneys carry the lion's share of the responsibility, it is appropriate that the lion's share of our story be devoted to them. We say "kidneys," for each of us possesses two, situated in the body cavity, one on either side of the spinal column, bean-shaped and about four and one-half inches long.

In order to understand the truly great role the kidneys play in the lives of every one of us, it is necessary to inquire into their history, to turn back the pages of time and trace from the beginning their story.

Our first ancestor was a single-celled creature that lived in the primitive ocean. From this creature, animals containing many cells appeared. Later, more complex creatures which enclosed sea water within their bodies arrived on the scene. Still later (countless millions of years later), animals possessing a backbone (the vertebrates) entered the picture. At long last, one particularly adventuresome creature abandoned the ancient seas and came ashore. It possessed fins, or flippers, that served as legs. It gave rise to the great family of amphibians, of which a modern example is the frog. These, in turn, were the ancestors of the reptiles such as the present-day alligator, and of the birds, and of that great warm-blooded group including man, that suckle their young, the mammals.

It must not be thought that evolution represented a steady, uninterrupted progression. Rather, it advanced by fits and starts. These fits and starts are explained by the mutation theory, which holds that unknown forces acting upon certain parent animals caused the birth of offspring that differed strikingly in one or more characteristics from their parents. If the change was one that made the offspring (sometimes called a "freak" or "mutant") superior, then the offspring would have an excellent chance of siring a new race. In the savage, brutal struggle for existence, even minor advantages favor survival; it is the lesson of evolution that successful or "fit" life forms have been the ones to survive. That is what is referred to by the phrases, "survival of the fittest" and "natural selection."

The Kidneys' Story

This brings us to the strange tale of how our kidneys came to be what they are. It is a story for which we are indebted to Homer W. Smith, a great physiologist, who read the dim and cryptic messages from fragmentary records of the past, interpreted their meaning, and presented the entire story in his *Lectures on the Kidney,* for physicians, and in his *From Fish to Philosopher,* a book designed for the laity.

The title of our story might well be, "Three Hundred Thousand Centuries of Experiment," for that is just the period it took the human kidney to reach its present stage of development.

Before plunging into the story, let us review a bit. The ingredients of the sea within us must be maintained at precise levels if we are to remain healthy. The most important of these ingredients is water itself. In addition to water we

have the electrolytes: sodium, potassium, magnesium, calcium, chloride, acid, alkali and others, plus a long list of lesser substances. Since the responsibility for maintaining constant the composition of the extracellular fluid rests heavily on the kidneys, the composition of our body fluid is determined not so much by what goes in the mouth as by what the kidneys keep. They are truly the master chemists of our sea within.

First of all, the kidneys excrete the ashes of the chemical fires of our body. They remove from the extracellular fluid a great variety of foreign substances indiscriminately absorbed by our digestive tracts. Yet these activities are but incidental to their greater job of maintaining the body fluid in an ideal, chemically balanced state. Our glands, our muscles, our bones, our tendons, even our brains, each is assigned one principal job, but the kidneys must perform an innumerable variety of functions. They must indeed be versatile and competent specialists. Bones can break, muscles can wither, glands can loaf, even the brain can deteriorate without immediately endangering our survival, but let the kidneys fail to manufacture the proper kind of extracellular fluid for just one hour, and neither bone, muscle, gland, nor brain can carry on.

In a word, the kidneys determine what kind of extracellular fluid we have. As Homer Smith says, "It might be said that the function of the kidneys is to make urine but, in a more considered view, one can say that the kidneys make the stuff of philosophy itself."

Each kidney is composed of innumerable (over a million) tiny units called "nephrons," which are microscopic in size. If one understands the nephron, then he understands the kidney. Each nephron consists of a tiny filtering bed drained by a long tubule. The filtering bed is much like that of a town water supply system. Over the filtering bed of each nephron passes a tiny blood vessel. A long serpentine tubule drains the filtering bed. At its far end, the tubule enters into a common collecting canal which drains hundreds of tubules. These canals join with larger canals and finally enter a chamber on the inner side of the kidney, called the pelvis. From the pelvis, a larger tube, the ureter, leads down to the bladder. Thence urine passes to the outside world.

The blood vessels that pass over the filtering bed curl down and around the tubule for purposes that shall be clarified shortly. As the blood passes over the filtering bed, everything in it except the red blood cells and certain large proteinate molecules filters through into the tubule. About 125 milliliters of liquid are thus extracted from the blood by both kidneys each minute. To supply this 125 milliliters of water, 1,200 milliliters of blood pass over the filter beds of the kidneys.

The tubules are lined by special cells which maintain close contact with the blood vessels entwining the tubules. This provides an opportunity for the tubule cells to transfer various substances from the blood to the tubular urine and from the tubular urine back into the blood. As the urine passes down the tubules, substances such as sugar, sodium, chloride and acids are transferred from the tubules to the blood. At the same time, certain waste products and foreign substances are extracted from the blood by the tubule cells and added to the urine. Of the 125 milliliters of water filtered each minute, 124 milliliters are recaptured by the tubule cells, leaving the one milliliter to be excreted in the urine. It is indeed fortunate that the tubule cells perform the function of recapturing water, else the average person would pass about 180 quarts of urine each day.

It is crystal clear that the kidneys are in many ways strange and devious devices that carry out their functions in a circuitous manner. Stranger yet is the story of how and why they came to be what they are. We shall touch only the highlights of the long and complex tale which began something over three hundred thousand centuries ago with a problem: regulation of the water content of the body.

The very substance of life is water. Primitive forms of life in the oceans had the same electrolyte composition (hence the same osmotic pressure) as the sea water about them. They had no problem, therefore, of gaining or losing water from their oceanic home since there was no difference in osmotic pressure of their body fluid from that of the sea. They did not have to excrete water from their bodies, only chemical wastes.

These early creatures hardly had what we would call kidneys. They did have a body cavity lined with a special membrane which extracted wastes from the fluid flowing freely within the cavity and discharged them into the sea through openings resembling the portholes of a ship.

Came the day when these extremely remote marine ancestors of man left the sea and entered the fresh water rivers of the newly formed continents. Why did they leave the security of their oceanic homes to invade continental waters? We do not know. Perhaps, as Homer Smith says, they were following a "protoplasmic urge" to search

for peace. They were destined never to find it. Instead, these ancient pioneers encountered such formidable problems that soon after they entered the fresh water rivers of the continents they developed defensive armor, became completely encased from head to tail in an impregnable covering of bony plates. The armor suggested that some terrible enemy, vicious, swift and merciless, lurked in those fresh water streams. Scientists long have thought that the enemy was some dangerous, predatory creature. Homer Smith has a more reasonable suggestion. He holds that the armor was developed through the working of the laws of natural selection and survival of the fittest to enable these fresh water forms to combat an invisible, destructive enemy that pursued them day and night without a moment's respite. The danger was the fresh water in which they found themselves.

When these wanderers of the sea took up their abode in fresh water, their body fluid still bore the chemical imprint of the sea. It was far saltier than the fresh water about them. "Water goes where salt is," and the salt within the bodies of these erstwhile sea animals attracted the fresh water about them through the law of osmosis until the animals were swollen to the point of bursting. We can well conclude that countless millions of them did burst. The ever present armor of those that survived probably was a defense against invasion by fresh water.

In time, a superior method of defense was developed but meanwhile the armor had served its purpose. Perhaps it served another purpose of equal significance: It apparently was from the armor coating of these primitive fresh water fishes that fins and flippers developed. It probably was fins and flippers that gave rise eons later to the useful appendages we know as arms and legs.

High Pressure Filtration System

The method that ultimately was developed to rid the body of surplus water was, in principle, simple. The heart simply pumped the water from the body. How did it do this? Through eons of evolutionary experiment, filtering beds were prepared by bringing tiny arteries into close contact with some of the ancient tubules which originally led from the body cavity to the outside. Thus was developed in a primitive form the functional unit or nephron of the kidney. The heart pumped blood to the filtering beds which filtered excess water from the blood, through the tubules to the outside world. Thus, the device by which water was pumped from the body was a high pressure filtration system which permitted not only water to be pumped from the body, but most of the electrolytes of the blood as well.

Since these animals could ill afford to lose so much water and electrolytes, it was necessary to modify the tubules so that they could recapture valuable constituents from the urine as it passed through the tubules on its way to the outside. Special cells developed in the walls of the tubules to recapture electrolytes and water from the tubular urine and transfer them back to the blood. The cells also developed the function of transferring material from the blood to the tubular urine. Thus it came about that the tubule cells became the ultimate mechanism for regulating the chemical composition of the blood.

Blood consists of plasma and red cells and in regulating its chemical composition, the tubule cells were regulating the chemical composition of that important portion of the extracellular fluid, the plasma. Plasma is in direct communication with interstitial fluid; hence, the tubule cells regulated the chemical composition of the interstitial fluid, too. Since the cellular fluid and the extracellular fluid are in indirect communication with each other, the tubules ultimately regulated the chemical composition of the cellular fluid.

In early animals, the nephrons were not gathered together compactly as kidneys. Ultimately this occurred and today the kidney represents a centralized collection of the ancient nephrons.

No Rest For the Weary

It might appear that these ancient fresh water fishes could relax in their watery paradise and enjoy peace; but peace was not to be their lot, for about this time gigantic earth movements occurred. A ridge of mountains higher than the Alps was thrust toward the skies in Northern Europe. Many continents were submerged beneath the sea and what land escaped submersion was plagued by extremes of climate, alternating between deluges of rain and periods of blistering drought.

Fishes of this period were faced with a bitter choice. They could invade the salt water marshes and be forced again to make drastic body alterations to preserve the integrity of their body fluid, or they could take up life in isolated fresh water pools which now and then shrank into stagnant swamps or even mud flats. Some chose the former course. Their valiant struggle, ultimately successful, is beyond the scope of this lecture. Others followed the latter course. They took to swallowing air in order to survive the stagnant water of the continents, and thus they "invented"

lungs. At the same time they prepared the way for the development of land animals. Later, one group of these fishes learned to use their fins for feet and crawled from one pool to another; they became amphibians, the ancestors of the reptiles, birds and mammals.

The kidney is not the same in structure and function in amphibians, reptiles, birds and mammals, nor is it even exactly the same in all mammals; but the differences are only in detail. The kidney that bears the closest resemblance to the human kidney is that of the great apes.

As we examine the human kidney, we should not be too disappointed to discover that it is certainly far from perfect. Indeed, it is far from efficient. Recall that it begins its work by filtering 125 milliliters of water from the blood each minute, then by means of the tubule cells promptly reclaims 124 milliliters of this amount as it passes through the tubules bound for the great outside world. The kidney thus qualifies as the greatest Indian giver of all time. The process is flagrantly wasteful since one-fourth of the pumping energy of the heart is directed toward supplying the kidneys with blood for this fantastic performance. The heart thus is exerting every effort against the tubule cells, trying with all its might and main to pump water from the body. The tubule cells are working just as hard to prevent the water from escaping. Our kidneys are thus constantly engaged, every minute of the day and night, in a knock-down, drag-out struggle with the heart. Our very lives depend upon neither side winning.

In addition to saving most of the water that is filtered through the filtering beds, the tubule cells reclaim nearly half a pound of sugar and three pounds of salt each day, plus significant quantities of electrolytes and other substances.

Imperfect and inefficient as they are, the kidneys each minute accomplish a task that would be far too complex for the most advanced Univac ever conceived by the brain of man. Yet, through the ages, the kidneys frequently have been regarded as the lowliest of organs. In the year 1804, a French chemist named Fourceroy displayed a remarkable dawning understanding with reference to the importance of the kidneys when he said, "The urine of man is one of the animal matters that have been the most examined by chemists and of which the examination has at the same time furnished the most singular discoveries to chemistry, and the most useful applications to physiology, as well as to the art of healing. This liquid, which commonly inspires men only with contempt and disgust, which is generally ranked amongst vile and repulsive matters, has become, in the hands of the chemists, a source of important discoveries . . ."

Some of the functions of the kidneys apparently are carried out independent of control from other organs. In other activities, the kidneys appear to act in response to blood-borne chemicals which signal when the volume and electrolyte composition of the blood have overstepped the bounds of normal. Amazingly efficient in their regulation of the chemical composition of the blood, the kidneys appear to have a strange disregard for conservation of potassium, which is poured out in the urine and lost, even though there may be a severe body deficit of the substance.

The story of the development of the kidneys through the long process of evolution reveals the laborious methods Nature has employed to solve the formidable physiologic problems of life. The same sort of tale could be told for each organ of the body, one by one. Each had an humble beginning in a primitive form of life. Each culminated in an organ, marvelously adapted to its life function, yet so complex as to challenge all the analytic powers of modern science.

Dangers of FDA Advertising Controls

IF one stops to think about it, the effect of government-muzzled (drug) advertising is one that curtails not only advertising, but also independent text which it monetarily supports. In other words, it tends to abolish freedom of the press. We begin to wonder if this had been one of the diabolical aims of the Fedicare faction. That is, not so much to protect people from poisonous potions as to strip power of the American medical professions; not so much to bless people as to boss them.—Northern Virginia Medical Bulletin.

97TH ANNUAL MEETING

of the

West Virginia State Medical Association

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AUGUST 20-22, 1964

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The President's Page

Communication As A Guide to Progress

SINCE the dawn of history all phases of man's progress have been largely determined as well as limited by his ability to communicate with his fellow-men. The means of communication used by man have been the same throughout the centuries. They are: The spoken word or sound; the written word or sign; the use of some form of language as a vehicle; action of the individual or group; the production of visual objects which are the result of man's ingenuity.

We can only determine our own progress or lack of it, as well as the quality of our thoughts and actions by referring to history's record, or to visual objects themselves, a tabulation of creativity to the present.

Medical communication is of vital importance to the medical profession and to each individual physician for without it there is no understanding either between physicians, or between the physician and the layman. This also applies to all other professions and vocations. Why should the medical profession be concerned about communicating with the general public, and with our government? In the past there has been an assumption on the part of physicians that it is sufficient to simply practice our profession since, indeed, it is time-consuming. As a result, there has been little interest in the other spheres of activities in our society. The world of medicine believed that this was the maximum expected by the public.

Recently, we have been rudely awakened. When we were made aware of the onslaught against the free enterprise system of medicine, we, of necessity, recognized the fact that the onslaught was against the entire economic system. Until comparatively recently we did not consider it necessary to protect our profession from the demagogue, the political opportunist, and the collectivist. These opponents of the free enterprise system have been and are using all the forms of communication to bombard the public with their propaganda for state control. The inroads that have already been made by these socialist minded forces, in the practice of medicine, in the business and industrial life of our Nation, and in other professions, are apparent to those who *choose* to see.

It is *imperative* that we, as physicians, continue to communicate in every possible way with the lay public and with our public officials on the county, state and national levels, and make it clear to them the reasons for the maintenance and protection of our free enterprise sytem. The people themselves must be educated and alerted. The latter is best accomplished on the county medical society level, where the formation and use of public opinion is of great significance. This includes influence upon our lawmakers and election of the best qualified men.

The individual physician plays the key role in this endeavor by his active participation in medical affairs and community affairs, thereby constructively influencing his contacts. It is imperative that this participation be *active*, not passive, and *immediate*.

Charles L. Goodhand

Charles L. Goodhand, M. D., President

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EDITORIALS

"The earlier a boy starts smoking, the more he is likely to smoke—the deeper he is likely to inhale and the sooner he is likely to die."

IT IS A COFFIN NAIL

This is just one of the startling findings in the Hammond report presented at the AMA Clinical Meeting in Portland, Oregon, in December, 1963. The Hammond report is one of the most authoritative studies concerning the cigarette menace. Other societies and associations, of as great medical prestige and soundness as the American Cancer Society, have been issuing similar findings and warnings for several years. The response of the AMA was to appropriate $500,000 for a long-term study on tobacco and disease.

It is true there are missing links between the cigarette and its profound influence on disease. It is also true that thousands of lives will be jeopardized if we await the final outcome of all investigations now under way. In the great medical discoveries of the past, benefits have not been withheld until the last bit of evidence was nailed down. There is a great deal of help that we can give now to the anti-cigarette campaign.

An association between cigarette smoking and chronic lung disease has been established beyond medical argument. Cigarette smoking accounts for the majority of cases of emphysema and emphysema deaths now outnumber tuberculosis deaths. It has been estimated that smoking ten cigarettes per day will lead to a diminution of four years in life expectancy for the average American. Cancer of the lung is from 20 to 30 times more prevalent in the cigarette smoker than the nonsmoker. This is our most deadly cancer with a salvage rate of only 5 per cent. A study of British physicians shows that at age 35 the chances of dying within the next ten years are 1-23 for the heavy cigarette smoker and 1-90 for the nonsmoker.

Americans had a long and sad experiment with alcohol prohibition and the most ardent crusader would not recommend a similar procedure in the anti-cigarette campaign. But there are many methods through which a smoker may be persuaded to forgo the habit. Many schools have well-organized programs to prevent cigarette smoking. Such instruction begins as early as the 5th grade and continues to graduation. Some local and state health departments have bureaus devoted solely to this problem. Small communities have adopted all manner of schemes to promote abstinence from cigarettes and group withdrawal has been a successful maneuver. One country in Europe has forbidden the advertising of cigarettes. Great Britain has plastered the land with a million posters showing the lethal menace of cigarette smoking.

Our Food and Drug Administration requires drug manufacturers to label many products . . . "may be habit forming." Many of these drugs

have less hazard of addiction and do not have the fatal potential of the cigarette. Day and night all media of advertising, promoting the cigarette, seem unaware of the grave dangers of long-time addiction of the product. Must the public be mesmerized by the fantastic claims of benefits of a product without an accompanying statement of its evils. Many investigators of this problem find the health hazard is greater in the use of cigarettes than in the use of alcohol. Yet the Federal Communications Commission will not permit advertising of hard liquor on the air waves.

An insurance medical director recently stated that cigarette deaths probably exceed 100,000 per annum. Yet this health problem is totally remediable.

Doctor Hammond concluded his Portland report with this statement: "Smoking is closely related to death rates and disease incidence and that generally the amount of cigarettes consumed and the degree of inhalation have a great deal to do with the incidence of death and disease."

DR. JESSE BENNETT—PIONEER PHYSICIAN

Elsewhere in this issue is an interesting story concerning a pioneer physician of this area. The article was written by Mrs. Melinda Hamilton and published in the *Point Pleasant Register.*

It is probable that Dr. Jesse Bennett performed the first successful Caesarean section in the new world. Because Doctor Bennett feared a recurrence of this surgical problem he also did a bilateral oophorectomy. The doctor never published the report of this operation because the patient was his wife and he feared the criticism, ridicule and disbelief of his colleagues. The consultant in this historical event was Dr. Alexander Humphreys of Staunton, Virginia, who was preceptor for three years to the renowned Ephraim McDowell. The exact place of the operation is in some doubt although one account states definitely that the surgery was done at Edom, in the Great Kanawha Valley.

Dr. Jesse Bennett was the first physician to locate in the Great Kanawha Valley. He was an unusually well educated and cultured gentleman. He held the degrees of Bachelor of Arts, Master of Arts and Doctor of Medicine. His country practice included the present area of Mason, Jackson and Putnam counties in West Virginia and also Gallia and Meigs counties in Ohio. He was the sole physician in this territory for 15 years. His practice ranged over 1500 square miles, with 300 to 500 inhabitants. His office was only 15 feet square, but large enough because there was little office practice in those days. The doctor's business was in the field.

In addition to the practice of medicine, Doctor Bennett was a major of militia and in custody of the arms of the county. He was a friend of Harman Blennerhassett and at one time feared Aaron Burr would sieze his armory so he caused the guns and ammunition to be buried in a secret spot. He served as a delegate to the Virginia legislature in 1808. He had a distinguished record as a military officer in the War of 1812 and was surgeon to the Mason County troops. At an army camp near Lake Erie he further demonstrated his advanced surgical competence in the suture control of hemostasis.

Doctor Bennett died in 1842 and is buried in the family cemetery in Mason County, West Virginia, on the land he settled.

Further information concerning Doctor Bennett would be gratefully received by *The Journal.* Perhaps the West Virginia State Medical Association may some day pay homage to the first physician to practice medicine West of the Alleghenies.

HYPERBARIC OXYGENATION

The term hyperbaric oxygenation signifies that oxygen is administered under pressure, and thus more oxygen is made available to the organism. Actually, hyperbaric oxygenation is a form of hyperoxia, that is an excess amount of oxygen in the system.

At approximately sea level the partial pressure of oxygen in inspired air is 150 mm. of Hg. Because of the water vapor pressure in the lungs and the pressure exerted by the alveolar carbon dioxide, the partial pressure of oxygen in alveolar air is around 100 mm. of Hg. Under this condition the hemoglobin is about 95 per cent saturated. If pure oxygen be administered, alveolar oxygen can be elevated nearly seven fold, that is, to 670 mm. Hg. More oxygen still can, of course, be made available if an animal is subjected to more than one atmosphere of pressure. Indeed, at three atmospheres of pressure the alveolar oxygen tension is raised roughly to 2,000 mm. of Hg. Since the hemoglobin can only be 100 per cent saturated, the excess oxygen is dissolved in the blood plasma.

It has been known for a long time that small animals made to breathe 80-100 per cent oxygen

continuously will die in about four days. It was shown by Comroe et al.[1] in 1945 that continuous exposure to high concentrations of oxygen at normal pressure produces reduction of vital capacity and substernal distress within less than 24 hours. Two years later it was shown by Ohlsson[2] that longer exposure results in dyspnea and increasing evidence of pulmonary hyperemia and edema. This work has been substantiated by other investigators.

Not only does oxygen in high concentrations produce pathologic changes in the lungs, but exposure to oxygen under pressures higher than two atmospheres may cause convulsions. It has been observed that some individuals are much more susceptible to this type of convulsions than are others.

Despite certain drawbacks produced by administration of oxygen under pressure, Boerema and his associates at Amsterdam and Smith in Glasgow have made notable and imaginative steps in increasing the volume of oxygen transported in the blood by means of hyperbaric oxygenation. Investigations are also in progress in the United States. Much of the work must still be considered in the experimental stage. Hyperbaric oxygenation has been used in a number of different conditions, among them are: carbon monoxide poisoning, anaerobic infections (especially gas gangrene), cardiac surgery, peripheral vascular accidents, hemorrhagic shock, and during radiation in malignant tumors (as an adjunct to radiation). Within the limits of this editorial only two clinical entities, which presumably are definitely improved by high oxygen pressure, will be discussed.

Clinically it has been reported by a group of workers in Amsterdam[3, 4] that patients suffering from gas gangrene, that is, infections produced by *Clostridium welchii*, are distinctly benefited by administration of oxygen under pressure. On the other hand, Smith et al.[5] of Glasgow, working with a small series, reported that while hyperbaric oxygenation is likely to prove helpful, it does not replace adequate primary surgery. Obviously, any procedure which lessens the mortality produced by gas gangrene deserves our respectful attention.

High oxygen pressure has been used, too, in the treatment of carbon monoxide intoxication. Hyperbaric oxygenation is of help in this condition because it increases the transport of oxygen, and this extra oxygen can immediately offset reduction in the oxygen carrying capacity of the hemoglobin.

The importance of immediate treatment of carbon monoxide poisoning cannot be over emphasized. Any agent or method which mitigates the danger of carbon monoxide poisoning is a most welcome addition to the armamentarium of the physician. It is recognized that following severe exposure to carbon monoxide irreparable damage may be done to the central nervous system. In extreme cases the effects are not unlike a cerebral decortication, and the victim is doomed to lead a vegetative existence the remainder of his life.

The matter of administration of more than one atmosphere of pressure produces problems which are not as yet entirely solved. However, a safe hyperbaric oxygenation chamber supplying up to 30 pounds per square inch above atmospheric pressure has been manufactured in the United States, and is presently available for research workers.

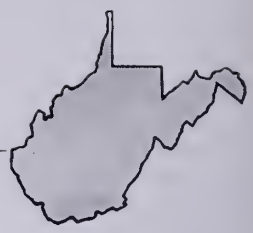
In summary, it must be emphasized that the use of hyperbaric oxygenation for the treatment of a number of clinical conditions is still in the experimental stage. High oxygen pressure may be of value in patients suffering from gas gangrene, and it is possible that oxygen under pressure may prove to be superior to the conventional treatment in carbon monoxide poisoning.

1. Comroe, J. H., Jr., R. D. Dripps, P. R. Dumke, and M. Deming. Journ. Amer. Med. Assoc. 128: 710-717, 1945
2. Ohlsson, W. T. L., Acta Med. Scand. Suppl. 190: 1-93, 1947.
3. Brummelkamp, W. H., J. Hogendijk, and I. Boerema. Surgery, 49: 299-302, 1961.
4. Brummelkamp, W. H., I. Boerema, and L. Hoogendyk, Lancet, No. 7275 I: 235-238 (Feb. 2) 1963.
5. Smith, G., W. Sillar, J. N. Norman, I. McA. Ledingham, E. H. Bates, and A. C. Scott, Lancet, No. 7259, II: 756-757, (Oct. 13) 1962.

Good Riddance to 'The Good Old Days'

Anybody who wishes for the return of "the good old days" so as to get things cheaper will realize that the price he has to pay is too great. This was the age of rickets and deformities. Maternal mortality was high. Each infant born had to struggle just to survive. Each adult was lucky if he could live to the age of forty. The great scourges were tuberculosis, pneumonia, typhoid fever, diphtheria, measles, scarlet fever, small pox, mastoid and brain abscess, meningitis and many other infections too numerous to mention, but all conquered now. Want to go back to "the good old days"? Would you want the penny prescription of yesteryear for the dollar ones of today, or the life of a century ago for the luxuries of today? Would you trade modern wonder drugs for old-fashioned, home-spun medicants? People should know that particularly in health matters, as elsewhere "cheap is cheap."—New York State General Practice News.

GENERAL NEWS



Winter Meeting of Council Held In Charleston on Jan. 5

The Council of the West Virginia State Medical Association approved a proposed program by the State Department of Health to improve immunization levels against diphtheria, pertussis, tetanus and poliomyelitis. The Council also approved a cooperative program of comprehensive health care for welfare recipients which would be instituted on a pilot basis by the State Department of Health and the Department of Welfare.

Dr. Ward Wylie of Mullens, center, President Pro Tempore of the State Senate and a member of the Council of the State Medical Association, is shown with Dr. L. J. Pace of Princeton, left, Chairman of the Council, and Dr. Frank J. Holroyd of Princeton, Chairman of the Association's Legislative Committee.

This action was taken during the winter meeting of the Council which was held at the Daniel Boone Hotel in Charleston on January 5. Also attending the meeting were members of the Association's Legislative and Public Service Committees.

Dr. George R. Callender, Jr., of Charleston, Chairman of the Medical Economics Committee, presented reports on the immunization and welfare care programs.

The Council recommended that in the proposed program of comprehensive care for welfare recipients that (1) the coordinator of such a program be a physician practicing in the area designated and (2) that the physician coordinator serve as liaison between the local county medical society and the administrative agency.

Doctor Callender also discussed a proposal to place the administration of medical welfare programs in the State under Blue Cross-Blue Shield, in addition to other facets of the committee's work.

Pre-Paid Health Care Legislation

Dr. Joseph L. Curry of Wheeling presented a report concerning pre-paid health care legislation and discussed a bill which had been prepared for introduction in the West Virginia Legislature. The Council went on record as unanimously approving the bill as amended.

Election of Honorary Members

The following members were elected to honorary life membership in the Association:

Physician	*Address*	*Society*
R. B. Talbott	Martinsburg	Eastern Panhandle
Creed C. Greer	Clarksburg	Harrison

King-Anderson Legislation

Dr. Frank J. Holroyd of Princeton, Chairman of the Legislative Committee, discussed the resumption of hearings before the House Ways and Means Committee on the King-Anderson bill.

The meeting was attended by Dr. L. J. Pace of Princeton, Chairman; Dr. Charles L. Goodhand, Parkersburg, President; Dr. Albert C. Esposito, Hunting-

Status of Bills Reported In Legislative Bulletins

Complete reports concerning action by the Legislature on bills of interest to the medical profession are incorporated in "Legislative Bulletins" that are being sent to members of the Association.

The Bulletins that are being mailed from the headquarters offices of the State Medical Association in Charleston are timed so as to take advantage of report dates by key committees and subsequent action by the Senate and House of Delegates.

Through the use of Bulletins, we will continue to bring to our members as promptly as possible up-to-the-minute activities. The reports that are, in effect, news stories, are being prepared and distributed in lieu of lengthly news stories that would ordinarily appear later in *The Journal.*

The final Bulletin will be mailed within a day or two after adjournment of the Legislature on February 8.

ton, President Elect; Dr. Seigle W. Parks, Fairmont, Vice President; Dr. D. E. Greeneltch, Wheeling, Councilor-at-Large; and Drs. Joseph L. Curry, Wheeling; Maynard P. Pride, Morgantown; Richard V. Lynch, Jr., Clarksburg; John E. Echols, Richwood; I. Ewen Taylor, Huntington; Ward Wylie, Mullens; Buford W. McNeer, Hinton; Richard W. Corbitt, Parkersburg; William B. Rossman, Charleston; D. Alene Blake, Oak Hill; and Mr. William H. Lively, Secretary ex-officio, and Mr. Jerry Gould, Executive Assistant, both of Charleston.

The meeting was also attended by Dr. Frank J. Holroyd, Princeton, and Dr. Charles A. Hoffman, Huntington, AMA Delegates; Dr. Thomas G. Reed, Charleston, AMA Alternate; Dr. George F. Evans, Clarksburg, Editor of *The Journal;* Mrs. Pat A. Tuckwiller, Charleston, President of the Woman's Auxiliary to the State Medical Association; Mrs. L. Dale Simmons, Clarksburg, Chairman of the Legislative Committee of the Woman's Auxiliary; Dr. George R. Callender, Jr., Charleston, Chairman of the Medical Economics Committee; Mr. William E. Mohler, Charleston, Attorney for the Association; Mr. Paul Hudgins, Bluefield; and Drs. John T. Chambers, John W. Hash, William L. Cooke, Page H. Seekford and Kenneth G. MacDonald, Charleston; S. William Goff and Robert M. Biddle, Parkersburg; N. B. Groves, Martinsburg; Jack J. Stark, Belpre, Ohio; J. C. Huffman, Buckhannon; Charles W. Merritt, Beckley; Stephen D. Ward, Wheeling; C. R. Davisson, Weston; John J. Mahood, Bluefield; and Everett H. Starcher, Logan.

PG Course in General Practice

A postgraduate course on "General Practice" will be presented at the Cleveland Clinic Educational Foundation in Cleveland, February 5-6.

The course, open to all members of the medical profession, is sponsored by the Cleveland Chapter of the American Academy of General Practice.

The fee for the two-day course is $20 and registration will be limited to 150. Further information may be obtained by writing Dr. Walter J. Zeiter, Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

Dr. Charles L. Goodhand of Parkersburg, right, President of the West Virginia State Medical Association, is shown with Mrs. Pat A. Tuckwiller of Charleston, left, President of the Woman's Auxiliary to the State Medical Association, and Mrs. L. Dale Simmons of Clarksburg, Chairman of the Auxiliary's Legislative Committee.

West Virginia Chapter, ACS, To Meet At The Greenbrier, Apr. 15-18

The annual meeting of the West Virginia Chapter, American College of Surgeons, will be held at The Greenbrier in White Sulphur Springs, April 15-18.

Dr. Jack C. Morgan of Fairmont, the president, will preside at the meeting and physicians throughout the State have been extended an invitation to attend.

Dr. Hu C. Myers of Philippi, the vice president, is in charge of arrangements for the meeting. Further information concerning the program will appear in a future issue of *The Journal.*

Medical Technologists Meet

The 15th Annual Meeting of the West Virginia State Society of Medical Technologists will be held at the Holiday Inn in Parkersburg, May 1-2. Medical technologists and associated laboratory personnel have been invited to attend.

Further information may be obtained by contacting Mrs. R. A. McDougal, M.T. (ASCP), 38 Willowbrook Acres, Parkersburg.

Members of the Legislative and Public Service Committees who met with the Council on January 5 included, seated, left to right, Drs. N. B. Groves, Martinsburg; Page H. Seekford, Charleston; Frank J. Holroyd, Princeton; Charles W. Merritt, Beckley; John J. Mahood, Bluefield; Joseph L. Curry, Wheeling; Robert M. Biddle, Parkersburg; and C. R. Davisson, Weston. Standing, Drs. Everett H. Starcher, Logan; S. William Goff, Parkersburg; J. C. Huffman, Buckhannon; John T. Chambers, Charleston; Stephen D. Ward, Wheeling; William L. Cooke, Charleston; and Jack J. Stark, Belpre, Ohio.

Revolving Loan Fund Established For WVU Medical Students

A revolving loan fund has been established at the West Virginia University School of Medicine by the Committee on Medical Education, Hospitals and Scholarships of the West Virginia State Medical Association.

This is in addition to the two $4,000 scholarships awarded annually by the State Medical Association to students enrolled in the first-year class at the WVU School of Medicine. Six dollars of the dues of each active member is earmarked for this fund.

The Committee, which met in Parkersburg on December 15, 1963, unanimously directed that $4,000 be placed with the West Virginia University Foundation to establish a division of the Charles Lively Memorial Scholarship and Loan Fund.

Dr. J. P. McMullen of Wellsburg, Committee Chairman, said these loans would be made under the following conditions:

(1) Loans shall be made only to those who have been determined by the Registrar of the University to be *bona fide* residents of West Virginia.

(2) Eligibility is restricted to members in good academic standing of the second, third and fourth year classes of the School of Medicine of West Virginia University.

(3) The applicant must demonstrate need to the satisfaction of the School of Medicine Faculty Committee on Student Welfare.

(4) The maximum loan available from this source to any student during one academic year shall be $400.

(5) Each loan shall bear interest at the rate of 4 per cent per annum beginning 1 year after receipt of the M.D. degree or 1 year after leaving medical school for any cause.

(6)) Full repayment will be expected by the end of the third year following receipt of the M.D. degree or following leaving medical school for any cause.

(7) The Executive Secretary of the West Virginia State Medical Association shall receive notification from the Chairman of the Medical School Committee on Student Welfare of the name of each recipient of a loan, and the amount of the loan.

(8) Each student receiving a loan from this fund shall be informed by the Chairman of the Medical School Committee on Student Welfare of the source of the funds from which the loan was made.

The meeting was attended by Doctor McMullen, the Chairman, and Drs. Clark K. Sleeth of Morgantown; Russel Kessel, Edwin Shepherd and Pat A. Tuckwiller of Charleston; Martha J. Coyner of Harrisville; Richard Hamilton of St. Marys; Richard V. Lynch, Jr., of Clarksburg; John M. Moore and M. B. Williams of Wheeling, Charles L. Goodhand of Parkersburg, President of the West Virginia State Medical Association; Seigle W. Parks of Fairmont, Vice President; and Mr. Jerry Gould of Charleston, Executive Assistant.

Another $500 Contribution To Scholarship Fund

Mr. Harry H. Carnahan, President of The Medical Arts Supply Company in Huntington, has made a contribution of $500 to The Charles Lively Memorial Scholarship Fund of the West Virginia State Medical Association. This is the sixth consecutive year that Mr. Carnahan has contributed the sum of $500 to the Scholarship Fund.

Under the program, eight students already have been awarded sholarships of $4,000 each to the West Virginia University School of Medicine.

A meeting of the Committee on Medical Education, Hospitals and Scholarships was held at the Chancellor Hotel in Parkersburg on December 15. Those attending were, seated, Drs. Richard V. Lynch, Jr., Clarksburg; Martha J. Coyner, Harrisville; J. P. McMullen, Wellsburg, the Chairman; Charles L. Goodhand, Parkersburg, President of the State Medical Association; M. B. Williams, Wheeling; and Seigle W. Parks, Fairmont, Vice President of the Association. Standing, Drs. Edwin M. Shepherd, Charleston; John M. Moore, Wheeling; Richard Hamilton, St. Marys; and Pat A. Tuckwiller and Russel Kessel, both of Charleston

Intern and Residency Training Programs Under Study

Representatives of four West Virginia Hospitals attended the first meeting of the State Medical Association's sub-committee on Medical Education and Hospitals in Morgantown on November 2.

The sub-committee was named in April, 1963, by Dr. J. P. McMullen of Wellsburg, Chairman of the Association's Committee on Medical Education, Hospitals and Scholarships. Its objective is to discuss intern and residency training programs with representatives of teaching hospitals throughout the State.

The Morgantown meeting was attended by Drs. M. B. Williams of Wheeling and Clark K. Sleeth, Dean of the West Virginia University School of Medicine, members of the sub-committee; Dr. William Sheils and Mr. Daniel Brown of Cabell-Huntington Hospital, Huntington; Dr. Daniel Hamaty, Charleston Memorial Hospital; Dr. Robert O. Strauch, Ohio Valley General Hospital, Wheeling; Mr. E. L. Staples, West Virginia University Hospital; and Dr. James E. Dyson, Jr., Director of the Division of Academic Communications at the WVU Medical Center.

Doctor Hamaty said that two years of post-M. D. hospital training was a minimal necessity. He pointed out the need for an academic atmosphere in the teaching hospital with an organized and well-conducted teaching program by the staff, and careful gradation of assignment of patient responsibility for the trainees.

Doctor Sheils voiced similar sentiments, as did Doctor Strauch, who added some interesting statistics. He said 52 per cent of hospital beds in the United States today are reported to be in hospitals with no training programs. Of the other 48 per cent, two-thirds are in hospitals with no affiliation with a medical school. In the operation of the National Intern Matching Program, 61 per cent of the applicants are matched to affiliated programs, 8 per cent to Federal programs and 31 per cent to unaffiliated "community" hospitals.

Doctor Williams spoke on the urgent future need for full-time chiefs of the respective clinical services in community hospitals desiring to continue or to develop programs of intern and residency training.

There was general agreement that any logical program of post-M. D. continuing education, both during and following the internship and residency, would need to be hospital-based, with the hospital staff having the responsibility and the necessary authority to assure the conduct of and participation in a program. The breadth of base of programs could be adopted to the particular needs of specific hospitals.

Mr. Brown suggested the possibility of a traveling educational consultant for West Virginia hospitals having training programs, to be supported jointly by these hospitals.

It was concluded that there is continuing need for further education of the physicians of the community hospitals with respect to their responsibilities in training programs. It was likewise concluded that there is a continuing need for education of the physicians of the schools of medicine to the potentials of training programs in community hospitals. Those in attendance agreed to pursue these educational goals in their respective spheres.

Dr. Richard W. Corbitt of Parkersburg, center, was elected chairman of the newly created West Virginia Commission on Postmortem Examinations at the organizational meeting in Charleston on December 27. Other members who attended were, seated, Dr. Oliver C. Eshenaur, Pt. Pleasant, and State Police Capt. T. A. Welty, South Charleston. Standing, Lynden S. Fisher, Charleston funeral director, and Floyd R. Tarr of Weirton, Hancock County Prosecutor.

Speakers Named for Oph. and Otol. Meeting at The Greenbrier

The 17th Annual Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology will be held at The Greenbrier in White Sulphur Springs, April 15-18.

Dr. James T. Spencer of Charleston, the president, announced that the following physicians will present papers on ophthalmology: Drs. Alston Callahan of Birmingham, Trygve Gunderson of Boston and John Henderson of Rochester, Minnesota.

The papers on otolaryngology will be presented by Drs. James M. Cole of Danville, Pennsylvania, Richard Farrior of Tampa, Florida, and Harold Tabb of New Orleans.

A one-day course on contact lens will be presented by the Plastic Contact Lens Company. The course will be held on Wednesday, April 14, the day preceding the formal opening of the meeting.

Physicians throughout the State have been invited to attend the four-day meeting. A registration fee of $35 will cover all scientific sessions and social functions.

Additional information may be obtained by writing the secretary, Dr. Worthy W. McKinney, Professional Park, Beckley.

State Physicians Honored by ACP

Two West Virginia physicians were among those recently designated as Fellows and Associates of the American College of Physicians.

Dr. Charles E. Andrews of Morgantown was elected as a Fellow and Dr. Irwin M. Bogarad of Weirton was selected as an Associate.

Dr. Paul A. Miller Keynote Speaker At Rural Health Conference

Dr. Paul A. Miller, President of West Virginia University, will be the keynote speaker at the American Medical Association's 17th National Conference on Rural Health in Columbus, Ohio, March 6-7.

Dr. Paul A. Miller

The theme for the meeting, which will be held at the Columbus Plaza Motor Hotel, will be "Health in a Changing Rural Environment." Topics of discussion will include medicine and religion, teen-age health problems and reports from selected states on rural health programs.

Doctor Miller will discuss "Changing Rural America—Guidelines and New Meanings," on Friday morning, March 6. He will be followed by Mr. Wesley E. Gilbertson, Chief of the U. S. Public Health Service Division of Environmental Engineering and Food Protection, who will speak on "Planning and Action in the Rural Fringe."

Dr. Earl L. Fisher of Gassaway, Chairman of the Committee on Rural Health of the West Virginia State Medical Association, will speak on "The Importance of State Rural Health Conferences" on Friday afternoon at 3:30 P.M.

The medicine and religion portion of the conference will feature Dr. Edward H. Rynearson, senior consultant at the Mayo Clinic and Dr. John A. Whitesel, chaplain at the University of Indiana Medical Center in Indianapolis.

The Saturday morning session will be devoted to "Teenage Health Tune-Ups." Mr. W. W. (Woody) Hayes, head football coach at Ohio State University, will speak on "Building Health Ideals."

13 Physicians Licensed by MLB To Practice in State

The Medical Licensing Board licensed 13 physicians by reciprocity at a meeting held at The Capitol in Charleston, October 28, 1963. The following physicians were licensed:

Chick, Ernest Watson, Morgantown
Dye, Robert Eugene, Welch
French, Frank Sanford, Berwyn, Pa.
Fuller, Charles Irving, Jr., Fairmont
Gillespie, Frederick David, Birmingham
Hamaty, Daniel, Charleston

Harrington, Albert Eugene, Elkins
Hill, Dean Franklin, Mullens
Mantini, Emil Louis, Morgantown
Meadows, Owen Curtis, Jr., Charlottesville, Va.
Pitsenberger, Henry Joseph, Belle
Ramsay, Allan Brodie, Beckley
Wolf, John Herman, Jr., Morgantown

New Association Members

Dr. Michel A. Glucksman, the Golden Clinic, Elkins (B-R-T). Doctor Glucksman was born in Brooklyn, New York, and was graduated from Swarthmore College. He received his M. D. degree in 1954 from the University of Buffalo School of Medicine, and served an internship at Meadowbrook Hospital in Hempstead, New York, 1954-55. He served residencies at VA Hospitals in Buffalo and Des Moines, Iowa, 1957-61. He served as a Captain in the Medical Corps of the United States Air Force, 1955-57, and was previously located at the VA Hospital in Cincinnati. His specialty is urology.

* * * *

Dr. Thomas J. Janicki, 1211 Quarrier Street, Charleston (Kanawha). Doctor Janicki, a native of Barrackville, was graduated from Fairmont State College. He attended the two-year School of Medicine at West Virginia University, and received his M. D. degree in 1961 from the Medical College of Virginia. He served an internship at Charleston Memorial Hospital, 1961-62. He is engaged in general practice.

* * * *

Dr. Philip M. Rubin, 1205 Quarrier Street, Charleston (Kanawha). Doctor Rubin was born in Huntington and was graduated from West Virginia University. He attended the two-year WVU School of Medicine and received his M. D. degree in 1958 from the Medical College of Virginia. He served an internship at the USAF Hospital at Lackland Air Force Base in Texas, 1958-59. He served as a Captain in the Medical Corps of the United States Air Force, 1959-61, and he served a residency at Charleston General Hospital, 1961-62. He is engaged in general practice.

* * * *

Dr. Thomas F. Scott, 1139 Fourth Avenue, Huntington (Cabell). Doctor Scott, a native of Huntington, was graduated from Dartmouth College. He received his M. D. degree in 1958 from the University of Michigan School of Medicine, and he interned and served a residency at University Hospital in Ann Arbor, Michigan, 1958-63. His specialty is orthopedic surgery.

* * * *

Dr. William P. Sinclair, Medical Arts Building, Wheeling (Ohio). Doctor Sinclair was born in Wheeling and was graduated from West Virginia University. He attended the two-year WVU School of Medicine and received his M. D. degree in 1955 from the Medical College of Virginia. He interned at Ohio Valley General Hospital in Wheeling, 1955-56, and served a residency at the Akron General Hospital, 1959-62. He served as a Lieutenant in the Medical Corps of the United States Navy, 1957-59. His specialty is internal medicine.

The only people who achieve much are those who want knowledge so badly that they seek it while the conditions are still unfavorable. Favorable conditions never come.—C. S. Lewis

State Launches All-Out Effort Against Rheumatic Heart Diseases

West Virginia has launched an all-out effort aimed at the eventual practical eradication of rheumatic fever and rheumatic heart disease. State Director of Health Dr. N. H. Dyer said that it could take as long as a decade before all program objectives were realized, but "with a bit of luck and a lot of cooperation" West Virginia still could become the first state in the nation to achieve practical elimination of these diseases.

In his weekly "State of the State's Health," Doctor Dyer pointed out that after months of planning, this two-pronged attack was prepared:

1. Primary prevention through extension of the rapid streptococcal detection program to every physician in all of the state's 55 counties.
2. Secondary prevention through major revisions in the penicillin prophylaxis program for indigent and medically indigent patients.

About three years ago, the Department of Health, in cooperation with the Kanawha Valley Heart Association, launched a demonstration program for rapid detection of streptococcal infections. By means of the fluorescent antibody technique, the State Hygienic Laboratory can usually have reports back to physicians within 24 to 48 hours. Swabs of suspected streptococcal infections are transferred to a special mailer, which will be supplied to physicians.

Much of the time needed for reporting is involved with getting mail to the laboratory, in South Charleston, and eventually it may be necessary to offer the services on a regional basis. This would speed up services in some sections by as much as one day.

Better Distribution of Penicillin

The second revision for 1964 will be aimed primarily at a better distribution of penicillin and improved follow-up procedures. Since September, 1952, with the aid of matching funds provided by the West Virginia Heart Association, the State Department of Health has administered a cooperative rheumatic fever prevention program. This program provides indigent or medically indigent patients who are certified by physicians with penicillin which is shipped directly from the Department to private physicians for administration to patients. The new routine calls for direct shipment from the vendor to local health units who will see that local physicians have sufficient supplies.

"By bringing the counties into the picture," Doctor Dyer said, "we hope fewer patients will be lost from the program. For example, in the past we have emphasized parent education since the responsibility for seeing to it that children take daily doses of drugs rests primarily with them. Through experience, however, we have learned that adolescents—who customarily rebel against restrictions and any type of regimen—do not adhere to the prescribed routine. By home visits and through working with teenagers, we should hope that adequate prophylaxis could be maintained in the majority of cases, thus preventing new attacks of rheumatic fever to be expected if the regimen is discontinued."

Streptococcal Infections Up

Throat swabs of a representative sampling of the school population taken recently in one county revealed that nearly one in ten children had streptococcal infections of the type that produces rheumatic fever. Since there are no baseline data for comparison there is no way of knowing if these findings are representative of the state as a whole. In a subsequent study, currently under way in another county, the rate is running even higher. Furthermore, reports from county health units indicate that the prevalence of streptococcal infections is about 30 per cent higher this year as against the same period in 1962.

Doctor Dyer emphasized that since nearly half of all streptococcal infections are of the asymptomatic variety, continuous chemoprophylaxis among patients with rheumatic fever seems to be the most rational approach to the prevention of further rheumatic heart disease. "There was a time when we believed that patients must take daily doses of antibiotics until early adulthood; we now know these patients must remain on the drugs throughout life."

While many forms of heart disease still defy efforts for prevention, rheumatic heart disease is the one type that stands out as almost completely vulnerable. Most significant is the fact that if chronic rheumatic heart disease were recognized as an entity in summaries of vital statistics, it would rank at least tenth among the leading causes of death in the state.

Medical Meetings, 1964

The following is a partial list of national, state and district medical meetings scheduled for 1964:

Mar. 6-7—National Conf. on Rural Health, Columbus, Ohio.
Apr. 13-16—AAGP, Atlantic City.
Apr. 15-18—W. Va. Acad. Oph. and Otol., White Sulphur Springs.
Apr. 15-18—W. Va. Chapter, ACS, The Greenbrier, White Sulphur Springs.
May 1-2—W. Va. Soc. Med. Technologists, Parkersburg.
May 15-17—W. Va. Chapter, AAGP, Charleston.
June 21-25—AMA Annual Meeting, San Francisco.
Aug. 20-22—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Oct. 1—Rural Health Conf., Jackson's Mill.
Nov. 16-19—Southern Medical, Memphis, Tenn.

Make Your Reservation Now!

Members of the West Virginia State Medical Association are urged to make reservations without delay for accommodations during the 97th Annual Meeting at The Greenbrier in White Sulphur Springs, August 20-22, 1964. Application forms for room reservations were enclosed in a bulletin mailed to each member last month. The completed forms should be mailed directly to the Reservation Manager, The Greenbrier, White Sulphur Springs, West Virginia.

Dr. Charles L. Goodhand of Parkersburg, President of the State Medical Association, was the speaker at a joint dinner meeting of the Parkersburg Academy of Medicine and the Woman's Auxiliary in Parkersburg on Thursday evening, January 9. Among those attending the dinner were, seated, Mrs. Robert C. Lincicome of Parkersburg; Mrs. Pat A. Tuckwiller of Charleston, President of the Woman's Auxiliary to the State Medical Association; Mrs. Charles W. Thacker, president of the Woman's Auxiliary to the Parkersburg Academy; and Mrs. Charles L. Goodhand. Standing: Doctor Goodhand; Dr. Robert Lincicome, president of the Parkersburg Academy; Dr. Pat A. Tuckwiller; Mrs. Athey R. Lutz and Dr. Lutz of Parkersburg; and Dr. Charles W. Thacker. (Photo courtesy of The Parkersburg News).

Regional GP Symposium Held In Morgantown on Dec. 8

A Symposium on the "Practical Aspects of Cancer Therapy," sponsored by the West Virginia Chapter of the American Academy of General Practice with the cooperation of Eli Lilly and Company, was held at the West Virginia University Medical Center in Morgantown on December 8.

Six members of the faculty of the WVU School of Medicine presented papers during the scientific session. The speakers were as follows:

Dr. Barbara Jones, Assistant Professor of Pediatrics; Dr. Paul C. Desper, Fellow in Endocrinology and Metabolism; Dr. Phillip J. Wright, Resident in Internal Medicine; Dr. Alvin L. Watne, Associate Professor of Surgery; Dr. George G. Green, Associate Professor of Radiology; and Dr. John B. Harley, Assistant Professor of Pathology.

The Board of Directors of the West Virginia Chapter, AAGP, met on the morning of December 7 at the Medical Center.

Seminar on Premature Care

The second annual seminar on "Premature Care" will be held at the Good Samaritan Hospital in Cincinnati on April 16.

Guest speakers will include Dr. David Gitlin, Professor of Pediatrics at the University of Pittsburgh School of Medicine; Dr. Bruce D. Graham, Professor of Pediatrics at the Ohio State University College of Medicine; and Dr. Arnold P. Gold, Associate Professor of Neurology at the Columbia University College of Physicians and Surgeons.

There is no registration fee for the one-day meeting, but physicians planning to attend are requested to contact Dr. James J. Englert, Chairman, Premature Seminar, Good Samaritan Hospital, Cincinnati, Ohio.

Refresher Course in Anesthesiology Planned at Medical Center

A two-day postgraduate course in anesthesiology will be held at the West Virginia University Medical Center in Morgantown, April 11-12.

The third annual refresher course is sponsored by the WVU School of Medicine and the West Virginia Society of Anesthesiologists, which will hold its Spring meeting in conjunction with the scientific sessions.

Guest speakers will be Dr. M. T. Jenkins of the Department of Anesthesia, Parkland Memorial Hospital, Dallas, Texas; Dr. Peter Safar, Professor and Chairman of the Department of Anesthesiology at the University of Pittsburgh School of Medicine; and Dr. C. R. Stephen, Professor of Anesthesiology at the Duke University School of Medicine in Durham, North Carolina.

Four members of the WVU School of Medicine faculty will present papers. They are Dr. Byron M. Bloor, Professor and Chairman of the Division of Neurosurgery; Dr. N. W. B. Craythorne, Associate Professor and Chairman of the Division of Anesthesiology; Dr. Walter H. Moran, Jr., Assistant Professor of Surgery; and Dr. Kenneth E. Penrod, Vice President of WVU in charge of the Medical Center.

Further information may be obtained by writing to Dr. N. W. B. Craythorne, WVU Medical Center, Morgantown, W. Va.

PG Course on Metabolic Diseases

A postgraduate course on "Recent Advances in Metabolic Diseases" will be presented by the American College of Physicians at the Mount Sinai Hospital in New York City, February 24-28.

The registration fee is $60 for ACP members and $100 for non-members. Further information may be obtained by writing to Dr. Edward C. Rosenow, Jr., Executive Director, 4200 Pine Street, Philadelphia, Pennsylvania, 19104.

Cardiac Symposium in Washington

A Cardiac Symposium will be held at the Marriott Twin Bridges Motel in Washington on April 1. The one-day meeting will be sponsored jointly by the Heart Association of Northern Virginia and the Washington Heart Association.

Physicians in West Virginia have been extended a cordial invitation to attend the meeting. Additional information may be obtained by writing Mrs. Anna C. Van Sickler, Executive Director, 609 North Edgewood Street, Arlington, Virginia 22201.

PG Course in Pediatrics

The Cleveland Clinic Educational Foundation will present a postgraduate course on "Progress in Pediatrics" in Cleveland, February 26-27.

The registration fee is $30 for the two-day course. Further information may be obtained by writing Dr. Walter J. Zeiter, Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio 44106.

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The Role of the Surgeon in the Management Of Chronic Ulcerative Colitis*

Edward S. Judd, M. D.

In former years the great emphasis in management of chronic ulcerative colitis lay on medical measures, a logical choice because of the distressing complications following multiple-stage operations. But many of the unfortunate patients were forced into repeated hospitalization while receiving whatever form of treatment the internists of the day could design. Recurrent distress of great magnitude was accompanied by overwhelming economic loss. What the surgeon could do was usually an ileostomy of sorts, sometimes producing a "double-barrel" stoma, and the dread of the complications following such ileostomy was what drove the internist to seek any other form of treatment. Many of those patients surviving the early ileostomy then had to submit to a series of segmental resections of the colon, amounting finally to complete colectomy in a number of cases.

A mild revolution was produced by the development of "skin graft ileostomy." This opened the modern era of surgical management of chronic ulcerative colitis. It is a matter of record, however, that the skin graft later might go on to form a stricture requiring surgical revision. The development of the "mucosal eversion technique" advocated by Crile and Turnbull, and the almost simultaneous development in England of the full thickness method ascribed to Brooke, have brought us tremendous improvement in surgical management. This means that all patients now should be scrutinized carefully for the possibility of colectomy with ileostomy, done preferably in a single stage. The great advantage in this method is immediately apparent to all who have witnessed its gradual evolution.

The Author

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In spite of these hopeful comments, Waugh, Beahrs and associates[1] have found that from 1954 through 1959, of 1230 Mayo Clinic patients hospitalized for chronic ulcerative colitis only 205 (16.6 per cent) ultimately came to surgical management. Is this figure high enough? Are we willing to rely too long on false hopes (steroids, antibiotics, amino acid therapy) when we could in fact eliminate not only much of the suffering but a tremendous amount of expense—financial, sociologic and other?

In passing, it is interesting to recall the enthusiasm shown for a time in psychotherapy for these patients. Observers are divided in their conclusions in this regard. My own thought is that any individual forced into having 20 or more bowel movements per day is naturally going to become upset, nervous and emotionally disturbed. We have witnessed great improvement in a few patients following psychotherapy, but perhaps this is merely an evidence of good, complete medical management.

The recent studies on auto-immunity states in the colon are worthy of considerable reflection. Production of striking changes in laboratory animals by these means warrants continuation of this type of study, as the changes do indeed resemble ulcerative colitis. At the present time the

*Presented before the second general scientific session of the 96th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 23, 1963.

exact practical application remains an open question.

The alert surgeon must be ready to adopt all adjuncts to put the patient in the best possible condition. He must be ready to decide for himself, after very close collaboration with the internists, whether or not a patient should be subjected to operation and, if so, when. Probably no field of abdominal surgery is demanding of a more exact decision. The surgeon of the modern era not only will do all in his power to justify widespread adoption of one-stage proctocolectomy, but also will be alert to identify those patients who should not be treated in this manner.

Nature of Complications of the Disease

Fistula.—An inherent complication of chronic ulcerative colitis is fistulae. These may be of numerous types, involving the skin of the abdominal wall, the perineum, other segments of colon, or even the small intestine. They complicate management for the internist and make preparation for surgery much more difficult.

Polyposis.—The polyp exhibited by many of these patients is simply an inflammatory island of mucosa giving rise to confusing roentgenologic changes. It is quite possible that true adenomatous polyps may develop also, and even the most experienced radiologist will be hard put to distinguish between the two types.

Obstruction.—A paradox may be encountered in the patient who is having extreme diarrhea with alternating periods of apparent obstruction of the bowel. This is the nature of the disease. The obstruction may be of the colon or of the terminal ileum or of both. Stricture formation is very common in ulcerative colitis and the x-ray picture will suggest at once the possibility of malignancy. In more recent years a condition now known as "toxic megacolon" has been reported with increasing frequency. This is a dread complication. The proximal colon may be so extremely dilated that it ruptures, and secondary distention of the small intestine makes the condition even more precarious. The exact mechanism of this change is not clear. One cannot ascribe it to steroids, as the condition was exhibited prior to the development of steroid therapy. When this complication is present it taxes the therapeutic ingenuity of internists and surgeons alike.

Perforation.—One might expect a perforation of the colon to be quite apparent on physical examination, but the nature of this disorder is such that "silent perforations" are not at all unusual. The patient may have numerous abscesses scattered about the abdomen without showing the signs one commonly associates with them. A distressing development is for perforation to become apparent after the patient has been in the hospital for a number of weeks under what was considered rather satisfactory medical management. I have wondered whether or not an abuse of the steroids has increased the incidence of perforation and I am inclined to think that this actually is true.

Hemorrhage.—More often than not, hemorrhage is of a chronic nature, so that severe anemia is the common result. Acute, massive, exsanguinating hemorrhage, however, is possible and, like perforation, can occur in the hospital while the patient is on what has appeared to be very adequate medical management. Here again, the relation to steroids is not clear cut but I, personally, have been very apprehensive that abuse of the steroids may lead to more frequent and more serious hemorrhage.

Developmental Retardation.—Earlier, everyone concerned was fearful of the development of infantilism. The ordinary results of surgery in an earlier day were such that children with ulcerative colitis were shielded carefully from surgical consultation but, in addition, pediatricians were certain that removal of the colon and establishment of ileostomy would produce arrested development. The consequence was that infantilism became a problem as the patient was allowed to harbor this disease through the years, only to arrive at a hopeless state. I am convinced that we should be operating much earlier on these unfortunate children and that the fear of early ileostomy is no longer justified.

Indications for Surgery

Indications for operative intervention are the complications of chronic ulcerative colitis as outlined above. In addition to those complications, secondary changes of varying degree such as pyoderma, arthralgia, eye changes and the like, must be kept in mind. More recently, chronic hepatitis or actual cirrhosis has been associated with this disease in a sequence difficult to assess. Unfortunately, once it has developed, even complete surgical ablation of the colon has not produced reversal of the cirrhosis.

The chance of carcinoma of the colon associated with chronic ulcerative colitis can no longer be denied. All observers agree that the longer the disease is harbored, the greater the risk of development of cancer. Everyone knows that once it develops it is very likely to be highly anaplastic, widely metastasized, and totally inoper-

able. This possibility alone should be enough to justify early colectomy, even though other factors may not be so overwhelming. It means that the alert surgeon will be operating for suspected carcinoma in some cases, as the x-ray demonstration of colonic strictures, polyposis and pseudopolyps will lead automatically to surgical intervention because there is no way to know in advance whether or not carcinoma is present already.

Intractability is a condition that should be much less formidable in the future than it has been in the past. As mentioned above, repeated prolonged hospitalization, with a very questionable result at the end of each such episode, appears to me a poor excuse for delaying surgical treatment. Ileostomy no longer should be regarded as the dread specter it once was, and the progressive internist well knows that its present risks should not be a barrier between the patient and surgical consultation. The situation of the badly depleted patient returning to the hospital several times every year for blood transfusions, a variety of antibiotics and sulfonamides, intravenous therapy, psychotherapy and so on, is not a pleasant one. I believe that in the present day we as physicians have a great deal more to offer these unfortunate patients.

We must realize that no one individual can make the decision in every case. The interpretation of "failure to respond to adequate medical management" is most difficult in some instances. The false sense of security produced in some individuals by prolonged use of steroids should not lull us into accepting this as a truly good result. Nowhere does clinical judgment play a more important part. The trite phrase "team effort" is truly justified in this situation. The proper timing of surgical management and the delicate interpretation of the psychologic factors involved in accepting existence with an ileal stoma call for the utmost in clinical finesse. The acute, fulminating form of chronic ulcerative colitis continues to be a worrisome factor even to the most experienced observer. This will tax the judgment of all of us. And the more modern counterpart "toxic megacolon" does little to set our minds at ease; it simply complicates the decision further.

Surgical Treatment

It is evident from the foregoing comments that my colleagues and I argue for total proctocolectomy, preferably in one stage, whenever feasible. Usually, surgical management of this disease requires complete sacrifice of the rectum but with all the modern adjuncts, this can be done in one stage with very reasonable morbidity and mortality rates. We never proceed with removal of the rectum at the first operation, however, unless the patient is obviously able to tolerate it. If the situation is questionable, we prefer to save this final step for another day. In this instance the sigmoidal segment may be so badly diseased that closure of this end as a stump would be foolhardy, and we never hesitate to exteriorize it as a retrograde mucous fistula. Ordinarily the patient improves in a striking fashion so that the rectum may be observed for a year or longer and removed at convenience. It is our impression that the development of carcinoma in the rectal segment is considerably less common than in the colonic segment. Sigmoidoscopic examination may keep the retained segment under observation but, unfortunately, stricture formation gradually makes accurate sigmoidoscopic visualization impossible.

Along with other surgeons, we learned at an early date that mere establishment of a stoma, whether by ileostomy or by colostomy, has little to offer in this disease and may involve considerable risk. The disease is in the colon, and removal of as much colon as possible at the first operation will accomplish the desired results. A very few patients at the Mayo Clinic have been treated even recently by emergency ileostomy without removal of any colon and have survived. In such instances, we have proceeded within 2 weeks to carry out the colectomy when the situation was far more favorable. There even have been isolated instances of colostomy performed as a life-saving measure, but these are so rare as not to affect our overall policy.

A possible justification for preserving the rectal segment, the hope that some day continuity may be reestablished, remains largely a hope. We have a small series of cases in which surprisingly good results appear to have been achieved, though later these patients may be forced to undergo removal of the rectum, making establishment of an ileal stoma unavoidable. In the segmental form of the disease, where the rectum appears quite normal, we may yield to the temptation of subtotal colectomy with ileoproctostomy. The patient is warned immediately that periodic checkups are indispensable and that the rectum may become diseased at a later date, demanding ultimate sacrifice. The University of Minnesota group recently has presented its experiences along these lines also[2].

Mere drainage of abscesses still is required on occasion, but this is only a temporizing measure. Segmental resection is the exceptional maneuver, as so many patients are doomed to progression of

the disease. Black and Culp[3] already have reported from our institution that better results accrue if subtotal colectomy is the choice, even when only short segments are involved.

Hospital Mortality.—The most recent report from our institution is that offered by Waugh, Beahrs and associates.[1] Of the 205 patients who underwent surgical treatment, in the 6 years ending with 1959, 18 died in the immediate postoperative period, producing an overall hospital mortality rate of 8.8 per cent. There were only 48 total proctocolectomies done in one stage, of which four patients failed to survive, giving a mortality rate of 8.3 per cent for that operation. Eighteen other total proctocolectomies were done in two stages and 21 in three or more stages, making a total of only 87 total proctocolectomies. We are confident that when the results are in for those cases managed surgically since that time, the record will be more impressive.

In that series, 57 subtotal colectomies were carried out. Continuity was reestablished at the same time or at a later stage in 29 of these patients, many of whom obviously had segmental ulcerative colitis only. The other 28 underwent ileostomy.

Results of Proper Surgical Management

Following the great majority of total proctocolectomies, we optimistically expect return to full activity in due course. This means that the patients can live a normal life and take their place in society, working every day and being entirely self-supporting. They can swim, golf, bowl or carry on any normal activity. They learn to develop confidence in the management of their ileal stomas. They may join ileostomy clubs and be a source of great solace to each other and to prospective candidates for similar operations. Most of them volunteer the statement that they wish they had undergone the surgery years sooner.

The surgeon is extremely cautious in young male patients, spending a great deal of time in removal of the rectum. He stays very close to the bowel wall if no malignancy is present. Annoying bleeding and troublesome dissection are the rule with such procedure but he carefully avoids the *nervi erigentes*, since impotence following removal of the rectum should not be any more common than that after severe perforating disease alone. Most of these young men should go on to the full status of normal fatherhood.

Although the disease usually is progressive, a quiescent state in the rectum may obtain for some while after subtotal colectomy and the patient may refuse removal of the rectum. We have not been in a hurry to urge removal in these individuals so long as the sigmoidoscope can be introduced satisfactorily to rule out malignant changes. There may be a progressive state in the rectal segment, however, despite complete diversion of the fecal stream. In such a situation not only will continuing perforation and abscess formation be a severe problem but exsanguinating hemorrhage may be witnessed. It is then evident to the patient that he must submit to removal of the rectum.

After an ileoproctostomy has been carried out one may expect entirely normal life, with only one to three stools a day. We must remember, however, that some of these individuals, perhaps even half, will later come to removal of the rectum with the inevitable permanent ileal stoma.

The Cancer Question

The surgeon will be forgiven if he again reminds internists and patients of the dread development: Cancer. It is difficult to know exactly the true incidence. Recent studies by Williams and Elliott[4] in a small series proved that of their 82 patients 5 actually had cancer, an incidence of 6 per cent. Waugh and associates[1] found that of their 205 patients 34 harbored malignant growths, an incidence of 16 per cent. These individuals had had chronic ulcerative colitis for an average of 18 years (range, 4 to 40 years). Thirty-seven other patients prior to surgery exhibited very alarming indications of possible malignancy which forced the surgeon to proceed with early operation in this 18 per cent of the series. Cancer was not found among this group, and it is of interest that the average duration of disease among them was only 8.6 years (range 2 months to 23 years). Bargen and Gage[5]earlier had analyzed the Mayo Clinic experience and concluded that the cancer factor was indeed a very serious one and that the likelihood of malignancy was reinforced by the presence of multiple lesions in a considerable number of cases.

Conclusions

Surgical treatment can be offered earlier to more patients suffering from chronic ulcerative colitis. Steroid treatment gives a false impression of security; increased incidence of perforation and hemorrhage has been observed. Intractability to medical therapy is increasingly acceptable as a surgical indication. Cancer of the colon continues as a dread possibility, the likelihood of which increases with the duration of chronic ulcerative colitis.

Modern types of ileostomy have changed the post-operative status drastically. In a small min-

ority of cases the rectum may be preserved. The hospital mortality rate following surgery continues to decline, despite increasing use of single-stage removal.

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Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

Contact Dermatitis in the Home and in Industry*

Eugene S. Bereston, M. D.

By the term, "contact dermatitis," is meant an inflammatory reaction of the skin to an external contact substance with which the skin is in direct association. There are two principal types: (1) primary irritant dermatitis and (2) true sensitization contact dermatitis. It is important to differentiate between the two. It is necessary also to separate contact dermatitis from atopic dermatitis. These definitions are essential to a clear understanding of the subject.

Pathologically, primary irritant dermatitis and true sensitization dermatitis cannot be differentiated. Primary irritants induce eczematous changes in the majority of individuals on the very first contact. Susceptibility to this type of damage neither is acquired nor specific, features which distinguish the true allergic reaction. Common primary irritants are cytotoxic agents such as strong alkalies, strong acids and solvents which damage cells directly. The reaction is relative, depending on the concentration, duration of exposure and local skin conditions. Soap which produces no irritation when used daily, will irritate the skin if left on for 24 hours in concentrated form. By contrast, in true allergic sensitization, only a minority of individuals ever acquire allergic hypersensitization to everyday substances (excluding some plants, topical medications and a few industrial contactants) with which they are in contact.

General Characteristics of Allergic Sensitization

(1) Refractory period. Time interval between first contact and beginning of sensitization.

(2) Incubation period. Interval between beginning of sensitization and first appearance of disease, usually 10 to 30 days.

(3) Reaction time. Interval between application of allergen to sensitized skin and first sign of reaction.

(4) Persistence of sensitivity. May disappear in a few months or gradually, over a period of years, or may last a lifetime.

Contact allergens usually are simple chemicals. Poison ivy antigen is a mixture of simple catechols. Mercury, a simple ion, may be a sensitizer. Contact allergens do not produce antibodies in animals.

Some chemicals form haptene conjugates with epidermal proteins directly. The easier they combine, the more potent the sensitizer with the conjugated product. The conjugation takes place with epidermal proteins. Other chemicals are metabolized first and the metabolite combines with an epidermal protein.

An adsorption complex with protein without conjugation may be an allergen in some cases. There is distinct evidence of antibody formation in contact eczematous sensitization. The antibodies can be demonstrated by passive transfer.

The lymphocyte is the carrier of the antibody and there are many lymphocytes in the blister fluid of contact eczematous dermatitis. In primary irritant dermatitis vesicles, polymorphonuclear cells predominate. The skin and mucous membrane are the sole shock organs in eczematous contact sensitization.

Acute contact dermatitis occurs with fairly sharp delimitation between the involved and the normal skin. The site of beginning reaction is dependent on the area of skin which has been exposed. In the case of materials which have not been intentionally applied to the skin or which are not articles of clothing, the most common sites of reaction are neck, face, hands, forearms and exposed surfaces of legs. The male genitals are a common site, involved by reason of transfer of allergen by the hands. If the allergen reaches the skin air borne in a finely divided state, the dermatitis frequently is diffuse on the affected sites, stopping sharply at the boundary of areas covered by clothing, for example, the collar line. If the allergen contact has been made through twigs or leaves or if the allergen has been transferred by the fingers, the reaction sites would be sharply localized, like a line of vesicles along a scratch mark.

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The hairy area of the scalp rarely is involved in contact dermatitis. In acute dermatitis of the face, for instance, the erythema and vesiculation ordinarily stop approximately 1 cm. or so short of the hairline.

Another striking feature of contact dermatitis is its tendency to involve the back of the hand rather than the palm, at least during the initial acute phase. Again, it tends to appear initially in areas that are not likely to be thoroughly washed and rinsed, that is, the upper eyelids, the skin surface under rings, and intertriginous areas such as those between the fingers.

Variable Course

The course of contact dermatitis is extremely variable, depending on the degree of hypersensitivity and the concentration of irritant or allergen reaching it, and the area of skin exposed. There may be no more than mild erythema with a suggestion of vesiculation or there may be large bullae on an acutely erythematous and edematous base. The initial reaction is strictly at the site of contact; within hours or days, however, secondary lesions may appear on the body without continuous exposure.

The course of acute dermatitis, provided that removal from responsible contactants is assured and that treatment is not of irritant or sensitizing character, is towards spontaneous involution. In a mild reaction the skin may be normal within a week or ten days; a severe reaction may require three or four weeks for complete involution.

Discovering the Cause

In simple, uncomplicated dermatitis the one thing necessary to produce involution of the eruption and prevent recurrence is to discover the causative allergen and prevent future contact with it. Sometimes this is easy but occasionally it is difficult, if not impossible. There are no completely satisfactory short cuts. Every contactant in the patient's environment, including those simple chemicals that he has used for years with complete immunity, must be considered. Once the diagnosis of contact dermatitis is established with certainty, it is extremely important to obtain the patient's cooperation in carrying out the required observations. It is distinctly worth-while to say to the patient: "This condition probably is caused by something that you touch or that touches you and, in finding out what it is, you can be a much better sleuth than I because you are with yourself day in and day out."

The history in relation to the cause of the dermatitis must be taken and re-taken. It is surprising how often patients do not remember some everyday activity that may be the solution to the entire problem. Certain specific situations may lead to more rapid resolution of the cause. One is distribution, that is, the usual site or sites of the condition. This may greatly reduce the list of possible causes.

The materials mentioned below as causes in certain sites simply are examples and their use neither is exclusive nor inclusive. On the head and neck, if the process is diffuse and the eyelids and periorbital skin are symmetrically involved, an air-borne contactant such as insecticide spray, or a volatile material (camphor, cigarette lighter fluid, gasoline), or ragweed pollen, or a cosmetic applied by spraying, or dichloricide and the like, is favored. In this distribution photosensitivity reactions may be confused with contact dermatitis. More localized eruptions are likely to be due to substances intentionally applied, that is, soap, face cream and other cosmetics; then there are substances which have been inadvertently transferred to the face by the hands, i. e., nail polish, poison ivy, primrose, and many other plants. Localized patches in certain areas may be readily explained at times, e. g., hatband dermatitis of the forehead, perioral dermatitis from mouth washes and toothpastes, cigarettes and filter tips, not to mention bubble gum dermatitis; or retroauricular dermatitis from mechanical irritation by spectacle frames; or sensitivity to white gold alloys or to plastics; dermatitis of the sides of the neck from perfume applied to the lower part of the ears, or from nail polish, or a fur neckpiece, or clothing.

Sites of Disease

Hands and Forearms.—The hands are regularly exposed to a vast multitude of irritants and sensitizers. To list them all would be impossible. Dermatitis that first appears on the backs of the hands and fingers, to the exclusion of the palms, and in which the area under rings is initially involved, may be suspected as being due to some external agent. The patterns on the hands may appear strange, in corresponding, as they do, to the chief sites of everyday, repeated contact, that is, in the handling of metallic money by a patient sensitive to nickel, in frequent knitting by a woman sensitive to wool, in the grasping of a steering wheel by a person sensitive to plastic, or in repeated contact with chromium alloys by a chrome-sensitive person. A common source of reaction on the forearms is the wrist watch, a wrist band, or costume jewelry.

The hands and forearms are the most frequent sites of initial reaction in industrial dermatitis.

The hand eczema of housewives forms a considerable part of the dermatologist's practice. Constant immersion of the hands in water alone, in soapy water, or in detergent water will, in many cases, lead to excessive drying, cracking, peeling and, in sensitization cases, vesicle formation. Household solvents and waxes also are potential trouble makers for housewives' hands.

Axillas.—These are fairly common sites of dermatitis. Lack of involvement of the hairy area, with involvement of the surrounding skin, is extremely suggestive of a reaction to a contactant. Antiperspirant creams and solutions, toilet water and perfume are common causative factors. Dyes and cleaning fluids remaining in recently cleaned clothing may cause trouble.

Trunk and Proximal Extremities.—Contact dermatitis in these regions most frequently is from cosmetics, or from some substance in clothing. Garters and elastic straps also are frequent sources of difficulty. Careful differentiation between a wide variety of other inflammatory processes, including seborrheic dermatitis and pityriasis rosea, must be made.

Genital Region.—This region, especially in the male, is particularly subject to chemical irritation. Materials commonly responsible for contact dermatitis are poison ivy, dusting powder, contraceptives and various topical medications, especially those used for relief of itching or for the cure of a fungal infection.

An interesting case in my private practice some years ago was that of a newspaper carrier who was in the habit of keeping a number of rubber bands on his left wrist, placing one around each newspaper before throwing it on the front lawn. He came to me with dermatitis of the left wrist and the genitalia. My knowledge that he was a newspaper carrier who wore rubber bands on his left wrist every day coupled with my question whether or not he used a rubber contraceptive resulted in a diagnosis of contact dermatitis due to sensitization to rubber which was confirmed later by a patch test.

Feet.—Contact dermatitis of the feet is quite common and, unfortunately, often is misdiagnosed as a fungal infection. Responsible excitants include repeated mild trauma, irritating and sensitizing materials in shoes, cement, rubber, dyes, foot powders, creams and liquids. The allergic mechanism operative in the development of persistent contact sensitization has much practical application.

Poison Ivy Dermatitis.—Administration of poison ivy antigen during acute dermatitis caused by this plant is dangerous, and is completely unsound from an immunologic standpoint. Moreover, there is overwhelming evidence that very often it does harm. The rule applies to administration of any compound responsible for an allergic reaction during an acute reaction to the compound in question. Attempts at hyposensitization by administration of crude extracts of oleoresins from the plant have been largely ineffectual because potency of such material varies and the dosages that usually are recommended are far below that required. Three or four injections cannot be expected to provide clinical protection for persons moderately or extremely sensitive.

The outlook for attaining significant levels for hyposensitization has been improved by discovery of a chemically pure allergen, 3-pentadecylcatechol, a substance naturally elaborated by the plant. Intramuscular administration of this antigen is superior to oral use. The exact course of treatment is an individual matter attuned to the particular person's level of sensitivity and his capacity to tolerate the drug without allergic reaction such as swelling and pain at the site of injection, or fever and urticaria and exanthematous eruptions, or malaise of constitutional reaction.

Considering all things, hyposensitization is not a procedure to be taken lightly and should be reserved for those who sustain numerous and extremely severe attacks of poison ivy dermatitis.

To find the cause of contact dermatitis in a given case, the history must be carefully elicited since often it yields the best facts concerning materials and agents to which the patient has been exposed. It will be of help not only with the contact dermatitis due to sensitization but with that due to primary irritant substances as well. By "primary irritant" is meant a substance which would be irritating to the skin of any individual, a substance such as an acid of strong concentration or an akali of strong concentration, or any similar substance. In other words, a primary irritant would be irritating to human skin generally whereas in true sensitization contact dermatitis only a small percentage of persons who have become sensitized to the particular substance would be affected.

The length of time to acquire sensitization to a substance varies with the individual. In some instances exposure to a substance may occur once, and on the second exposure the individual would show evidence of sensitization dermatitis. On the other hand, some persons are exposed thousands of times over periods of many years

before contact dermatitis develops. This factor is difficult for the lay person to grasp. Very often when a diagnosis of contact dermatitis is made, either in industry or in the home, the patient, when confronted with the fact that he has become sensitized to a substance commonly used in his work or to a cosmetic preparation commonly applied to the skin, which has been used with safety for many years, will react with: "But doctor! I've been using this so long! It could not possibly be this!"

I am reminded of another private case. The patient, an old man, had been working with cement and plaster since he was a young boy, all in all, probably a matter of more than fifty years, without any difficulty. Finally, contact dermatitis developed and on patch testing was found to be the result of sensitivity to cement. His hands cleared on treatment and he was advised to avoid contact with cement. He could not believe, however, that after fifty years he no longer could work with cement and he laughed at what I told him. A few days later he was back, with an acute exacerbation of his cement contact dermatitis due to his becoming re-exposed to cement. Although he learned it the hard way, he finally learned his lesson, that sensitization may take place many years after repeated exposure. And this is true in all types of sensitization contact dermatitis.

The Patch Test.—The patch test is of great value as an aid in the diagnosis of contact dermatitis, and is easily carried out under ordinary conditions. It should never be performed, however, during an acute exacerbation of the disease as the latter may become much worse if the offending substance is applied, even in the small quantity needed for the test. Patch testing should be reserved for use after the original dermatitis is gone. A list of the substances to which the patient was exposed, either at home or in industry, is then made and the testing material applied, preferably to an area in which the skin is not too thick, the usual sites being the flexor surface of the forearm, the medial aspect of the arm or, occasionally, the back.

Various safe dilutions of patch test materials have been made. A strong concentration, when used, sometimes may lead to primary irritant dermatitis of the patch test site rather than the true sensitization reaction. For example, in testing sensitivity to soaps or to other substances similar to soaps, very high dilutions must be made. The same is true of many other substances, particularly of some of those used in industry. To list the concentrations to be used is beyond the scope of this paper. Tables listing the concentrations, however, are available in standard texts. Many substances used in the home and in industry can be utilized for patch testing just as they are, e. g., most cosmetic preparations, hair tonic and hair dressing, but not shampoos that contain soap. Patch tests should be read within 24 to 48 hours; in case they are negative they can be looked at again at 72 hours for a delayed reaction since a weak reaction may be missed if they are read, say, within 24 hours alone. The patch test is a fairly good index of contact sensitization dermatitis and the method is used routinely by the dermatologist seeking the cause of contact dermatitis in a given case.

Any practitioner may do patch tests in his office. The important things to remember are to refrain from testing while the acute dermatitis is in full bloom and to avoid the use of too strong a concentration of test material when the patch test is made. In some instances dilution of the test material can be made with water and in others with oil, depending on the solubility.

Patch Test and Usage Test.—The usage test is employed in all types of dermatitis in which the patch test is negative. Sometimes a usage test may be positive. The usage test approximates natural exposure better than the patch test, which is artificial.

Occupational Skin Diseases.—Paracelsus, the first to write about occupational diseases, noted changes in the skin caused by salt compounds. Agricola, during the same period, described ulcers which he observed. The classic work for the 18th century was written by Ramazzini, in 1700, in which he made many observations on occupational skin diseases that remain true to this day. Ramazzini noted that bakers had strong, thick hands that often became swollen and painful, however, as a result of dough kneading. He observed also that millers and sievers of corn contracted an itching dermatitis which he stated was caused by an invisible parasite present in cereals. He described fissures caused by lye on the hands of washerwomen, and ulcers of the legs among salt miners; callosities of the buttocks of hostlers due to riding; varicose veins and ulcers of the legs of workers whose occupation necessitated long, continued standing.

In this country, there has been added interest in occupational diseases since World War I, when the chemical industry underwent great revival and expansion. The USPHS, in 1928, set up its Office of Dermatoses Investigations, now called the Dermatology Health Unit of the Occupational Health Program, which is concerned al-

most exclusively with the study of occupational and other forms of contact dermatoses. Today, a majority of our states have laws which provide for compensation to workers for occupational skin diseases caused by substances found to be skin hazards in the state in question. A few states compensate for all skin diseases which can be shown to be of occupational origin. Estimates of the incidence of industrial skin diseases in this country vary widely, from 2 per cent of all skin diseases to 20 per cent of all skin diseases.

The USPHS made studies among more than 100,000 workers in various factories and found that in a period of one year 1 per cent of all workers in these factories were affected by occupational dermatoses. This figure does not include burns, splashes of acid, or alkali, nor pyogenic infection of occupational skin wounds which affected approximately 10 per cent of 72,000 workers in an automobile factory and 10 per cent of 2,500 workers in a chemical and dye factory. Principal industries with a high rate of occupational dermatoses are synthetic resin manufacturers (7.5 per cent) chemicals and dye manufacturers (7 per cent), tanneries (3.5 per cent), oil refining (3.3 per cent), candy manufacturers (3 per cent), fabric dyers (2 per cent), rayon manufacturers (2 per cent), steel manufacturers (1.5 per cent), fur dyers (1 per cent), rubber manufacturers (1 per cent), glass manufacturers (1 per cent) and automobile manufacturers (0.4 per cent).

Factors in Occupational Disease

Race.—The USPHS, in 1945, in a study of 41,628 cases of occupational dermatitis covering seven states, reported wide variation in occurrence in a particular industry or occupation. The principal materials of exposure were petroleum products, alkalies, solvents and plants.

There are certain predisposing causes in occupational dermatoses. The negro, for instance, is much less susceptible to occupational dermatitis than the white man; he is less susceptible to the action of certain skin irritants. In industries such as dye manufacturing and those calling for work on grinders, where there is exposure to dyes, tar and irritating dust, many firms will employ only negroes because it has been found by actual experience that the latter are less sensitive to skin irritants. The same is true of dry cleaning establishments, in which process cutaneous irritation from solvents is the major hazard. On the other hand, the negro, for some reason unknown, is especially subject to the development of keloids, these often following burns, cuts or a traumatic injury.

It has been noted that the skin of the mongolian is dryer than that of the white man, owing to lack of oil. The mongolian exhibits a tendency to xeroderma and his skin is especially sensitive to friction and pressure.

Brunette whites such as those whose origin is in the Mediterranean area are less likely to be affected by solvents and dehydrators than the blonde Scandinavians and members of similar races; also, they can withstand greater exposure to sunlight.

Type of Skin.—Different types of skin within the caucasian race make a difference in sensitivity. Many factories will not employ persons with thin, blonde skin in occupations that would bring them in contact with potential irritants. Thick, oily skin better withstands the action of fat solvents contained in soaps, turpentine, naphtha, benzol, trichlor-ethylene and carbon tetrachloride. On the other hand, in occupations in which oil, grease or wax is likely to soil the clothing (oil refineries, machine shops, garages), I have observed that individuals with hairy arms, legs and seborrheic skin are more likely to show up with acne-like lesions and folliculitis.

Perspiration.—While perspiration normally acts as a protective agent by diluting those external irritants, it has been observed that in the worker who perspires excessively, dermatitis is more likely to develop on exposure to solid substances which become irritants when moist such as calcium oxide which, in the presence of moisture, becomes slaked lime or calcium hydroxide, or to substances such as sodium carbonate, or soda ash, which irritate only when they are in solution. The substance, in order to affect the skin, must wet it and will act on it either by chemical combination or by extracting moisture or fat from the skin. That means that only those substances that are more or less soluble or miscible in the secretion of the skin are capable of producing irritation. The excessive perspiration combined with friction will macerate the skin also and thus will make it less resistant to the action of external irritants. The pH is of importance in that it affects the solution of the skin irritants. It has been shown that the pH of perspiration varies with the individual and at different times in the same individual anywhere from 4.5 to 7.5, a range which marks change from acidity to alkalinity. Haxthausen, in working with metal dermatoses of allergic contact origin, found that he could sensitize individuals with nickel and cobalt more readily when the skin was in an alkaline state.

Diet.—Diet is another factor which influences perspiration pH, and may create greater sus-

ceptibility to industrial dermatitis. Sulzberger showed that diet influences sensitization in guinea pigs. Saito has shown that the sensitivity of the skin of rabbits to croton oil was increased when they had been rendered acidotic by diet. He noted also that cutaneous sensitivity in rabbits was increased by rendering them alkalotic by intravenous administration of sodium bicarbonate. The sensitivity of the skin was reduced even below normal, however, when hydrochloric acid was administered to a rabbit which previously had been rendered alkalotic or when a solution of sodium bicarbonate was administered to a rabbit which had been rendered acidotic.

Age.—In addition to the adolescent's predisposition to acne, age seems to have an influence on sensitivity to external irritants. Most of the workers affected with acute industrial dermatitis are young, new workers. It may be that either they have become immune or hardened to the chemicals, or they are less careful in handling them. On the other hand, there are chronic, eczematoid types of industrial dermatitis which usually occur in workers of middle age or beyond.

Sex.—Due to its greater dryness, the skin of women is more sensitive to external irritants than that of men. Much of the dermatosis seen among women consists of keratosis pilaris. Also, women are prone to notice slight irritations of the skin to which men would pay no attention. During menstruation and gestation, there is increase in perspiration which well might be a factor in greater sensitivity at such times. Actually, a lesser number of claims for compensation are made by women which, however, may be accounted for by three factors: (1) cleanliness of habits, that is, washing to remove irritants from the skin, (2) a lesser number of women than men are employed in hazardous occupations and (3) women seek first aid for skin disease earlier than men and thus prevent more serious involvement.

Season of Year.—Occupational dermatitis is more prevalent in warm weather, with less clothing worn and contact with external irritants more likely to take place. Excessive perspiration also is a factor during warm weather. In those industries, however, in which the clothes become saturated with skin irritants or in which dust filters through clothing, dermatitis may arise more frequently in winter, because in cold weather the workers are less inclined to take cleansing shower baths after work.

High humidity and heat favor the formation of prickly heat; in warm weather, therefore, in tropical climes, vesicular and bullous lesions of the skin are not uncommon. Secondary infection of such lesions may occur and other skin diseases are a factor.

Pre-existing Dermatoses.—Pre-existing skin disease, especially that of the itching type, in which scratching tends to rub in any irritant that may be deposited on the skin, also predisposes to contact dermatitis.

Lichen planus and psoriasis are well known for their response to trauma. Thus, physical or mechanical injury may be the cause of these lesions, at the sites of trauma. This is termed "Koebner's phenomen," or "isomorphic response." In individuals with acne who are in contact with insoluble cutting oils, aggravation of the acne may develop. Lupus erythematosus of the local or systematic type can be aggravated by exposure to ultra violet light. In atopic dermatitis, flare-up from exposure to irritant dust and greasy compounds often may occur.

Cleanliness.—Both cleanliness of the industrial environment and the individual worker are important, and frequent daily baths are indicated. The chemical causes of occupational dermatoses may be divided into primary irritants and sensitizers, just as in all contact dermatoses.

Allergy.—A primary cutaneous irritant is an agent which will cause dermatitis by direct action on the normal skin at the site of contact if it is permitted to act with sufficient intensity or in sufficient quantity for a sufficient length of time.

The cutaneous sensitizer is an agent which does not necessarily cause cutaneous changes on first contact but which may effect such changes of the skin that after five to seven days or more, further contact with the skin over the same parts of the body may cause dermatitis.

The primary irritant has a definite chemical or physical action on that portion of the skin with which it comes in contact. It forms a chemical combination with the skin or extracts essential ingredients from it, resulting in total destruction, burn or inflammation, depending on the concentration of the chemical and the length of time of exposure. The primary irritant denatures the skin. It also may be a sensitizer; exposure to it may so condition the skin that further contact, in dilute solutions or short periods of time such as previously would have caused no trouble, now may result in dermatitis. For example, a wool dyer with apparently normal skin noticed a dermatitis after a 7-day exposure to a dye containing 0.5 per cent potassium dichromate, and patch tests on distant sites of normal skin, using this concentration, gave positive reactions. Potassium chromate in strong concentrations is a pri-

mary skin irritant; an 0.5 per cent concentration will not affect normal skin. Such a dermatitis, therefore, can be called allergic. Highly allergic patients react to much lower concentrations.

Then, again, an individual who works with TNT will work for seven days or more before dermatitis develops, and patch tests on distant sites of normal skin will give positive reactions. This also is allergic because TNT will not affect normal skin. Such undue sensitivity or allergy is specific, is present all over the skin; it is not confined to any special, vulnerable area. It is true, also, however, even in allergic dermatitis, that open abrasions, or sites with thin layers of skin such as the bend of the elbows, may be more sensitive than areas of normal skin. There is no sensitivity before exposure to substances that are not primary irritants but five days or more after exposure a certain percentage of exposed areas will become sensitized. The percentage sensitized is in direct proportion to the degree of exposure to the sensitizing potential of the chemical. Some chemicals have far greater sensitizing potential than others. Poison ivy, for instance, has a greater sensitizing potential than chocolate. Approximately 2 per cent of workers handling small tetryl pellets become sensitized and dermatitis develops, whereas it develops in 50 per cent of workers in a tetryl drying house who become covered with tetryl dust. Similarly, dermatitis will develop in a large percentage of persons exposed to poison ivy, whereas there will be comparatively few cases among those handling chocolate.

When the fact that a large majority of cases of occupational dermatoses are caused by substances such as alkalies, acids and corrosive salts is considered, it is realized that only a small percentage are due to allergy. Such is not the case, however, among wearers and users of finished products. Here, allergy is the most frequent cause of dermatitis, as shown by the fact that the finished products are harmless to the wearers in the majority of the population. Furs, dyes, cosmetics and the like, worn and used by millions, cause dermatitis in only a few persons. In patch tests with fur dyes, leather dyes and hair dyes on individuals suffering from allergic dermatitis due to their use, respectively, we occasionally have found that the positive reactions to the patch tests increased in intensity after the first appearance, became eczematized, and persisted for many days, sometimes weeks.

In the compilation of many thousands of cases of occupational dermatitis from reports of various state compensation boards, it was found that in 80 per cent of cases the disease was due to a primary irritant. Allergenic substances such as plants, dyes and rubber, however, were the cause in approximately 20 per cent.

Sensitizers are allergenic chemicals. In ordinary circumstances, these substances affect only a small percentage of persons exposed but in extraordinary circumstances such as massive exposure for a long period, a much larger percentage will become sensitized. By sufficient exposure a few of these substances can produce sensitization in everyone.

The tendency to hypersensitivity may be inherited or it may be due to a defect in the defense mechanism of the skin such as, for instance, deficiency in the skin glands, causing dry skin, or pigment deficiency, causing hypersensitivity to light. The opinion held by some observers, namely, that acquisition of allergy to one substance broadens the sensitivity base and thus predisposes to sensitivity to other nonrelated substances, is accepted by some dermatologists but not all. Almost any chemical can be a sensitizer. Some chemicals, however, have greater sensitizing power than others. Phenolformaldehyde and the alkaline bichromates, for example, have greater sensitizing powers than the synthetic dyes or rubber accelerators. Usually the organic primary irritants have greater sensitizing powers than those organic compounds which are not primary irritants.

Symptoms of Occupational Dermatitis.—Symptoms of occupational skin disease depend in large measure on the cause or the clinical type of the lesion. In cases in which the cause is a concentrated irritant or in those caused by hypersensitivity where the onset is sudden, the patient notices itching, which is followed by erythema, papules, vesicles, edema, oozing and crusting in the exposed parts. The eruption is an acute, moist eczema. The inflammation may be arrested in the early stages and, if due to a chemical, usually improves during the week with the patient away from work. Symptoms may not develop for a period of time varying from a few hours to a few days after contact, and in certain cases (hypersensitivity) it may take years of contact to become sensitized. It is likely that in such cases an established immunity was broken down. In some cases only mild dermatitis develops and the worker is able to continue working and finally becomes immune. In others the dermatitis is of such severity that the patient must stop work. In the severe case immunity does not develop as often as it does in the case of milder degree. Immunity, if it does develop, generally lasts only

for a short time, that is, from one week to one month after the patient has discontinued work; in a few cases, however, immunity may last for many years. The worker who suddenly can become sensitized to materials he formerly handled for many years without trouble and who reacts with severe dermatitis, never becomes immune.

In the case of exposure to a mild irritant over a long period of time the early symptoms are not annoying, consisting only of mild irritation followed by thickening of the skin and loss of skin elasticity. Later, however, cracks and fissures develop and the open sores are irritated and kept inflamed by entrance of more of the causative agent. Ulcers result and usually heal with difficulty while the patient is working. In such cases, the picture of chronic, fissured eczema is presented. Dehydrating agents such as salt, sugar and low concentrations of lime and formaldehyde may cause such lesions. These cases are not due to allergy but to exhaustion of a defense mechanism of the skin. Substances such as mineral oil, grease, paraffin, chlorinates, synthetic waxes, coal tar and pitch can cause not only dermatitis but, if allowed to stay in contact with the skin, will block the pores, irritate epithelium of the skin glands and cause comedones, acne and cysts which may become infected and result in folliculitis and boils. Petroleum, unrefined paraffin, grease, tar and pitch cause epithelial proliferation which may result in keratoses, papillomata, or epitheliomas of the exposed parts. Tar, pitch and petroleum also may cause scrotal cancer.

Points in Diagnosis.—In the diagnosis of occupational skin disease, the following factors are of significance: (1) a carefully elicited history of the eruption, (2) sites of eruption, (3) distribution of eruption, (4) the patch test, (5) course of eruption and (6) characteristic appearance of lesions.

Case Classification.—Industrial dermatitis cases may be classified according to the outline below:

(a) Acute contact type.
(b) Chronic contact type.
(c) Folliculitis and acneiform types, including chloracne.
(d) Neoplastic type, benign and malignant.
(e) Hypopigmentary and hyperpigmentary disturbances.
(f) Miscellaneous forms.

Treatment.—First, find the cause and then eliminate it from the patient's environment or protect him from it, if possible.

In acute dermatitis, compresses or soaks of aluminum acetate solution 1 : 30, steroids locally, steroids orally or parenterally, or both, antihistamines and mild antipruritic lotions are useful.

Conclusions

(1) Contact dermatitis is an ever present condition, both in the home and in industry.

(2) It is necessary to differentiate between the primary irritant type and the sensitization type.

(3) The patch test, usage test, history and clinical observations are diagnostic aids.

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A Useful, Stimulating Device

APPARENTLY, those responsible for the new (drug) laws, and those charged with writing the regulations under them, believe that physicians behave like marionettes, manipulated by the manufacturer on the strings of his advertising insistence. This is not to be described as a stupid viewpoint but rather one indicating colossal ignorance of the physician's way of doing things. Drug advertising is neither a time waster, a physician manipulator, nor a miracle worker. It is a useful device, capable of reminding, stimulating or aiding the physician.—Northwest Medicine.

A Special Report by the Medical Economics Committee

George R. Callender, Jr., M. D.

In view of the great interest in the activities of the Medical Economics Committee it was decided that frequent progress reports should be published in *The Journal*. At the beginning of the year we had a number of active projects. Of great interest has been the development of a plan for the medical and surgical care of welfare patients under Blue Cross and Blue Shield. Early in the fall of 1962, under the direction of Dr. D. E. Greenelteh and Mr. William R. Huff, executive director of the West Virginia Hospital Association, an initial meeting was arranged between representatives of the Department of Welfare, National Blue Cross and Blue Shield Plans, West Virginia Hospital Association, and the West Virginia State Medical Association.

Following months of study, a plan was formulated and presented last fall to the Joint Committee on Government and Finance, which had been directed by the Legislature to make a study of the proposal.

Additional details were obtained and presented along with revised cost figures on January 7, 1964. The plan was developed with the idea of supplying the same medical and hospital coverage as currently provided by the Department of Welfare, but with improvement in the scope of the program as recommended by the West Virginia Hospital Association and the West Virginia State Medical Association.

Outline of Proposed Plan

Basically, the Hospital Association has prepared premium rates based on 100 per cent reimbursable cost for 30 days hospital care.

The Council of the West Virginia State Medical Association has repeatedly recommended improvements in both the MAA and GMH programs during the past year. The inequities in the present MAA fee schedule, the inadequacy of the GMH fee schedule, the limited scope of both programs and inadequate legislative appropriations have all been discussed at length with the Commissioner of the Department of Welfare.

The Author

- **George R. Callender, Jr., M. D., of Charleston, Chairman of the Committee on Medical Economics of the West Virginia State Medical Association.**

A solution to these problems of medical care for the indigent and medically indigent aged may well rest in the development of the Blue Plan. The proposal embodies the following improvements in the medical care programs:

(1) Equal number of days of hospital care under both the MAA and GMH programs.

(2) One fee schedule for both MAA and GMH programs which would be similar to the present MAA schedule, but with an adjustment of the schedule in areas of previous inequities.

(3) Coverage for both acute and chronic diseases.

The premium rates have been calculated by the National Association of Blue Cross and Blue Shield Plans. The cost of the premium would be determined on an annual basis with adjustment for the next fiscal year to be based on the experience of the first 6 to 8 months of the previous year's coverage.

In view of the advantages of this plan the West Virginia Hospital Association has offered its support to the extent that if estimated premiums would prove to be insufficient to reimburse the hospitals during the 12-month period, care would be rendered without charge until the beginning of the next fiscal year when a new premium contract would become effective.

The Council of the State Medical Association also has approved the recommendation that physicians participating in such a program accept pro-rata fees if necessary during the first year of operation.

A representative of the Continental Casualty Insurance Company attended one meeting of the interim committee and was scheduled to present a proposal at the meeting on January 7. It is our

understanding the company decided against submitting a proposal at that time.

Further Study Needed

The members of the legislative interim committee expressed much interest in the proposal; however, in its final report to the Legislature on January 30, 1964, the Joint Committee on Government and Finance stated that the proposal was not acted upon pending further study. Therefore, there is no possibility that the administration of the welfare program will be changed this year.

Activities of Joint Conference Committee

Additional welfare problems have been handled by the Joint Conference Committee. The most pressing, other than those mentioned above, has been the rapid increase in the amount of money expended on drugs under the MAA and GMH programs.

There also exists such problems as excessive paper work, inconveniences to patients and the questioning by county welfare officials of drugs prescribed by physicians. In an attempt to solve some of these problems, a new prescription blank was prepared and distributed in February.

The prescription is to be given to the patient who presents it to the pharmacist and he is then required to sign the prescription blank in acknowledgment of receipt of the drugs. The drugs will be supplied without prior authorization and this should eliminate much of the present paper work and inconvenience to the recipient.

The Department of Welfare has under study a request that some means of identification of welfare recipients be made available to physicians and pharmacists in order to prevent the financial loss which may result from dispensing prescribed drugs to those not eligible for care.

List of Physicians Published

On September 12, 1963, *The Charleston Gazette* published an article listing the names of physicians in the State who had received more than $5,000 from the Department of Welfare for services rendered to welfare recipients during the 1962-63 fiscal year.

In an editorial column appearing in the same newspaper a few days later, Mr. Thomas F. Stafford stated that the medical welfare program was being abused by a number of physicians throughout the state.

The following letters were mailed to Mr. Stafford, Mr. W. Bernard Smith and to each physician listed in the original article:

September 16, 1963

Mr. Thomas F. Stafford
The Charleston Gazette
Charleston, West Virginia

Dear Mr. Stafford:

In your editorial of September 14, 1963, you stated "Bernard Smith and his staff are powerless over the pill-pushers who charge $3.00 everytime a welfare patient comes through the door." The following information is sent not in criticism but for your information.

In March, 1962, the "Joint Conference Committee of the West Virginia State Medical Association" was established to work with the Department of Welfare on all problems of the Department related to the MAA and GMH programs, arising either within the medical profession or the Department of Welfare. Further committees were established in each welfare district called District Review Committees for the purpose of handling any irregularities at the district level, with all problems which could not be solved at this level to be referred to the Joint Conference Committee.

Since the establishment of these committees all problems have been given careful consideration and appropriate action taken. It was felt by the members of the West Virginia State Medical Association that the committee had fulfilled its purpose well and at the last meeting of the Joint Conference Committee, Mr. Smith stated to the committee that it had done an excellent job.

During this first year and a half the physician members have had difficulty in obtaining statistical data in regard to the monthly expenditures of the MAA and GMH programs and have not received during this entire period any statistical evidence of "abuse" by any member of the medical profession. It has not received to this date from the Department of Welfare statistics such as published by you on September 12, 1963. If it was felt by Mr. Smith that these figures were in themselves evidence of "abuse" it would seem only proper that he present these figures to the Joint Conference Committee for study.

You may rest assured that in the same mail in which you received this letter, Mr. Smith will receive a letter requesting that we receive a statistical breakdown of the figures made available to you for the purpose of review and decision jointly with the Department of Welfare as to

whether there is any evidence of abuse or whether these physicians, in fact, should receive praise and public recognition for services rendered to the indigent and medically indigent of the State of West Virginia.

Respectfully submitted,

(Signed)

George R. Callender, Jr., M. D.
Chairman, Medical Economics Committee,
West Virginia State Medical Association

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September 16, 1963

Mr. W. Bernard Smith
Department of Welfare
Capitol Building
Charleston, W. Va.

Dear Mr. Smith:

On Thursday, September 12, 1963, an article was published by Mr. Thomas Stafford entitled "Smith Aims Ax at Medical Costs." In the fifth paragraph the following was stated, "Five doctors collected more than $25,000 each. They were: Abraham Tow of Logan, $44,391; Erwin Chillag of Logan, $40,596.27; Lewis R. Elias of Montgomery, $32,860.47; Clyde A. Smith of Beckley, $25,703.67; and Arthur C. Litton of Charleston, $25,798.76." Farther along in the article it enumerated physicians receiving payments of $5,000 or more. Also the figures of amounts of total payments to physicians of $2,073,225.48 was stated.

On Saturday, September 14, 1963, Mr. Thomas Stafford stated in his last paragraph, "This problem can be corrected only if the medical profession will . . . start policing the 'abuses' which are slowly destroying its public image."

In view of the above article, as Chairman of the Medical Economics Committee of the West Virginia State Medical Association, I request that the Commissioner make available at the earliest possible moment a statistical breakdown of the amount of payments made to the members of the West Virginia State Medical Association, whose names appeared in the article stated for services rendered during the 1962-1963 fiscal year.

Specific breakdown for proper evaluation at this time must separate payments for MAA patients from GMH patients and give the number of patients treated in each category; separation of fees for physicians' services from reimbursements for drugs and medical supplies in each category; and fees for inpatient services either private hospital or clinic.

Knowing of your extreme concern in regard to this problem, I am sure you will expedite the collection and submission of this material to us at the earliest possible moment.

Sincerely yours,

(Signed)

George R. Callender, Jr., M. D.
Chairman, Medical Economics Committee
West Virginia State Medical Association

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September 18, 1963

My dear Doctor—

In the September 12, 1963, issue of The Charleston Gazette, Mr. Thomas Stafford published an article in regard to the amount of money paid to approximately 75 physicians who received more than $5,000 in the fiscal year 1962-1963 for the care of all classes of patients under the Department of Welfare. Your name was among those listed in the article.

We recognize that this amount may represent reimbursement for drugs and medical supplies as well as physician services. On September 14, 1963, Mr. Stafford published an article referring to the "abuses" evident by the amount of money received by physicians from the Department of Welfare.

As Chairman of the Medical Economics Committee, I would like to know what action you believe is indicated either by the individual physicians or the West Virginia State Medical Association?

I have discussed this matter with the President of the Association, Dr. Charles L. Goodhand, and he has approved sending this letter to the physicians mentioned in the article.

Sincerely yours,

(Signed)

George R. Callender, Jr., M. D.
Chairman, Medical Economics Committee
West Virginia State Medical Association

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As of this date, Mr. Smith has not supplied the information requested.

From letters received from the individual physicians involved, considerable insight was obtained as to the real problem of medical care of the indigent and medically indigent aged of West Virginia. Many of these facts were included in a speech your chairman presented before a recent meeting of the Young Democratic Club of Kanawha County. A copy of this speech was

directed as a memorandum to Gov. W. W. Barron and a meeting with the Governor and Mr. Smith has been requested.

Compensation

There has been considerable Compensation activity. The recommendations of the Compensation Sub-Committee (to be published in the April issue) were presented recently to the Commissioner. During the discussion of standardization of disability evaluations, the Commissioner requested that he be furnished the AMA publication "A Guide to the Permanent Impairment of the Extremities and Back," and the American Academy of Orthopedic Surgery's publication on "Measuring and Recording of Joint Motion." We have complied with these requests.

We also discussed the recommendations during a meeting with Governor Barron. He suggested that the Compensation Commissioner and representatives of the State Medical Association meet with him to discuss implementation of the recommendations. A meeting with the Governor has been requested.

Medicare Program

There have been some complaints recently in regards to fees for service paid under the Medicare Program (Medical Care Program for Dependents of Members of Uniformed Services).

Under our contract with the Office for Dependents' Medical Care, the physician renders a bill based on his usual fee for service. There is in effect, however, a maximum fee which can be paid for specific services both medical and surgical. There have been a few instances where the usual fee for services has exceeded this maximum. The fiscal administrator of the program, Mr. Ray A. Wyland, Executive Director of Parkersburg Medical-Surgical Care, Inc., has been requested to bring to the attention of the Office for Dependents' Medical Care the fact that inequities do exist in the fee schedule.

The maximum fee schedule for services has been reviewed in view of the average income of the actual participant. The schedule in all but a few instances is well above the present service policies of Blue Shield now in effect in West Virginia, covering a higher average income group. If the physician does not feel that he can care for a Medicare recipient for the maximum allowed fee, he may accept the patient on a private pay basis only and render to the patient his usual fee for services.

Special Studies

The largest problem falling under special studies is the formulation of the West Virginia State Medical Association's relative value index. This index is being prepared on the basis of the usual fee for service, using as close as possible the recommendations of the individual surgical and medical specialty, laboratory and x-ray relative value units.

The relative value index will therefore differ from the professional service index of the National Association of Blue Shield Plans. This project is progressing concurrently with the development of the compensation fee schedule which will be based on this index.

We plan to present the index for approval at the annual meeting in August. Approval of the compensation fee schedule, we trust, will be obtained by the various specialty groups well before that date.

Comments from Membership Invited

As chairman of the Committee on Medical Economics, I want to assure the members of the Association that the committee welcomes constructive criticism and other comments concerning our activities.

. . . education is man's going forward from cocksure ignorance to thoughtful uncertainty.

KENNETH G. JOHNSON.

The President's Page

The Status of Current Medical Legislation

MEDICAL legislation has been moving along somewhat rapidly in recent weeks on both the State and National fronts. The fronts referred to are the State and National legislative bodies, and the thinking and action of a citizenry that forms public opinion. Public opinion, in turn, has a major impact on the final actions of the legislative bodies. The factors involved in the ultimate formation of public opinion are many and devious. I refer you to any standard text on government and politics for a complete analysis of this subject. May I repeat again, as I have emphasized in the past, that the efficiency of communications between individuals and between groups plays a major role in the final decisions of legislative branches of government.

The 1964 session of the West Virginia State Legislature has just adjourned. The medical legislation of greatest import, a pre-paid, voluntary, non-profit, consumer sponsored, health care bill, containing safeguards advocated by the West Virginia State Medical Association, was passed by the Legislature in the final stages of the regular session.

There were two bills introduced in the Legislature relating to this subject—one sponsored by the West Virginia State Medical Association and the other by a citizens group and the UMW, AFL-CIO, and other interested parties.

The final bill that was passed by the Legislature is a strong measure that can have the approval of the State Medical Association as it contains those basic requirements of protection and freedom of choice for which we fought. These provisions are: (1) Truly consumer sponsored plans: A corporation may not accept from private agencies, corporations, associations, government agencies, groups or individuals, payment for or on behalf of any subscriber of all or any part of the cost of subscriptions for direct health care services to be rendered; (2) Fiscal reserves are required for financial protection of subscribers; (3) Physician and health care representation on boards of directors of all plans; (4) Strict supervision by State Insurance Commissioner; (5) Specific guidelines established to provide direction for the Insurance Commissioner; (6) Individual contracts submitted to subscribers must state exact nature of benefits, and exclusions, terms and conditions of cancellation of contracts; (7) Cost to subscriber clearly outlined, and (8) Limitation on types of investment of plan funds.

The medical profession has many good friends who are members of the State Legislature, representing both political parties. I wish to thank these Senators and Delegates on behalf of the State Medical Association for their fine assistance and the demonstration of the courage of their convictions.

Congress, now in session in Washington, has before it the 1963-64 version of the King-Anderson Bill. The Ways and Means Committee of the House of Representatives completed hearings on the bill (H.R. 3920) on January 25. The present indications are that the committee will vote on the bill in the near future.

The bill known as "The Hospital Insurance Act of 1963" differs little from the bills introduced in previous years. However, the main difference is that the present bill (H.R. 3920) provides benefits for those over 65 who do *not* have Social Security, the benefits to be paid out of the general revenue and not out of Social Security taxes. It retains the provisions for benefits for those over 65 who have Social Security, these benefits to be paid out of Social Security taxes. It differs from the Anderson-Javits Bill of 1962 in that the option to use private carriers has not been included. The Senate and American public opinion defeated the bill that year.

The current King-Anderson Bill must be defeated in committee, if possible, for the following reasons: (1) It interferes with the free choice of hospitals, nursing homes and physicians; (2) It is compulsory for all concerned; (3) The cost will reach unknown heights and will be paid by greatly increased payroll taxes; (4) It is not insurance but is taxation, as ruled by the Supreme Court; (5) It is socialistic and is so admitted by the adherents of socialism, and (6) The *need* for *this* legislation cannot be demonstrated. It is being met by family responsibility, private insurance, and the Kerr-Mills Law.

The medical profession must meet this challenge immediately, as it has many times in the past, with the help and cooperation of the citizens of the Nation who believe in the "free enterprise system" and the ideals of individual freedom and dignity.

Charles L. Goodhand

Charles L. Goodhand, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

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EDITORIALS

ON GUARD, FELLOW SONS OF AESCULAPIUS

An article in a recent issue of *Medical Economics*, entitled "New Trends in Malpractice Suits," records the report of John H. Tovey, L.L.M., on the discussions which he had with several members of the National Association of Claimants Counsel of America. The membership of this organization includes many of the leading malpractice attorneys in this country.

From the report it seems obvious that some of the predatory members of this association are out to "get" any doctor who is in any manner lacking in vigilance or allows the vagaries of human nature or the whims of the patient to undo his treatment. The ancient Code of Hamurabi is apparently to be revised in modern form by these attorneys to penalize physicians for any accident or result of treatment which is not deemed good by the patient.

Television shows that encourage patients to sue doctors, as well as doctors who publicly attack the quality of medical care, are also reported as responsible for the wave of prospective malpractice persecution. To the occupational hazards of physicians, such as exposure to infection and pestilence, more frequent coronary occlusions, long hours of work, shorter life span, and forced neglect of families and friends, must now be added the threat of legal harassment, possible unjust disgrace, and the loss of life's savings by lawsuits. We must take proper measures against this plague.

What are some of the preventive measures suggested in this article? Do the work yourself and do not allow nurse or aid assistants to do it; have examining tables fastened solid or strapped to keep patients from squirming or falling from them; keep patients hospitalized longer if necessary; have witnesses to and make copies of all instructions to the patient and to office and hospital personnel. Add to the cost of medical care if necessary (and you must do this at times) to avoid any shadow of liability.

Of course the patient will eventually have to pay the cost of these extra precautionary procedures.

Ours is an ancient and honorable profession. We, by the efforts and sacrifices of our predecessors and ourselves, have caused the disappearance of many of nature's plagues, have learned to repair many of her mistakes in development, and have even overcome many man-made injuries to man. Our profession has helped increase the human life span by some 20 per cent in our own century.

The physical and mental strain, as well as the financial cost to a young man who becomes a

well-trained physician, has become enormous. When one of my greatly honored preceptors was asked if he would in the light of present day developments again study medicine at this time and go through it once more, he replied, "Not unless I felt that I had to."

Many of us felt that we were called upon to enter our honored profession. Most of us have endeavored in every possible manner to so live our lives that we have tried to protect our patients in every way possible and to honor our calling. Let us never become lax or indifferent. Let us always remain vigilant and conscientious. But if we are to be persecuted let us in good faith retaliate and defend ourselves, and then may the protective saints and the guardian angel hover over my son as the torch of healing passes from my hand to his in this threatening age.

MEDICAL NEWS OF THE TIME

Speaking of famous physicians like Bennett and Beaumont, it may not be true that all our pioneers were of the same moral and professional fiber. In a recent edition of the *Charleston Gazette-Mail,* W. C. Blizzard reported an interesting tale concerning Dr. Samuel W. Crawford of Berkeley Springs who was lynched by his fellow citizens, more particularly his brother-in-law, on August 24, 1876.

The reasons for this arbitrary treatment are not well defined. The rumor said he had poisoned an old friend with arsenic but postmortem study by the medical examiner of the times failed to support this charge and arsenical poisoning is one of the easier methods of destruction to detect.

Numerous other rumors and charges were made concerning the doctor, such as stealing horses, cheating at cards and cohorting with women. Apparently the doctor had too many female patients, but how could a handsome well-built young man avoid such a lopsided practice.

Our records fail to disclose membership in the West Virginia State Medical Association, so we have only Mr. Blizzard's statement concerning this unfortunate Morgan County physician.

Anyway, the editor has been told frequently that the prime function of *The West Virginia Medical Journal* is to portray the medical news of the time; so here it is, even though it does appear Doctor Sam did little to shine the public image of the healing arts.

THE NEW LAW

The Legislature has gone home and we may now contemplate our new pre-paid medical care law. This law sanctions the corporate practice of medicine by non-profit groups who can secure a charter and get the operating approval of the State Insurance Commissioner.

The law permits a new and different approach to medical practice in West Virginia. It gives a less dubious legal standing to some groups who have practiced corporate medicine for a long time. Although a statement has been made that confusion exists in the section of the law pertaining to sponsorship, we have been advised by competent attorneys that the language in that section definitely prohibits labor unions, private agencies, corporations, or associations from sponsoring such plans.

It has been stated that one purpose of the new law is to improve rural medicine. West Virginia's rural population continues to diminish and the economic plight of many rural areas will not now support a solo practitioner. Only muddled thinking can foresee a corporation comprising a group of physicians and administrators thriving in rural West Virginia.

Single practitioners, groups and partnerships already flourish in West Virginia cities. Any reputable licensed physician, general practitioner or specialist, can develop a satisfactory practice in our West Virginia towns and cities without resorting to corporate practice.

It is hoped Blue Cross-Blue Shield and private insurance companies will now find it desirable to provide home office care on an optional prepaid basis. There is a growing demand on the part of the public for complete medical coverage. This demand can best be met by agencies already established, for through these channels medicine can still retain the proper patient-physician relationship without interposition of a corporation.

The effect of the law on medical care will be reported through *The Journal* as corporate practice may develop in West Virginia.

State Native Honored

Monroe J. Rathbone, a native of Parkersburg who is Board Chairman and Chief Executive Officer of the Standard Oil Company of New Jersey, served as National Chairman of the 1964 Heart Fund Campaign which was conducted during the month of February.

Although he is now a resident of Summit, New Jersey, Mr. Rathbone still maintains close personal and business relationships with his native state.

GENERAL NEWS

Dr. Perry E. Gresham Honor Guest At 97th Annual Meeting

Dr. Perry E. Gresham, President of Bethany College, will be among the honor guests at the 97th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 20-22.

Dr. William E. Gilmore of Parkersburg, Chairman of the Program Committee, announced that Doctor Gresham had accepted an invitation to appear as a guest speaker prior to the opening of the first general scientific session on Thursday morning, August 20.

Doctor Gresham, who has served as President of Bethany College since 1953, received A. B. and B. D. degrees from Texas Christian University and completed requirements for the Ph.D. degree at the University of Chicago and Columbia University. He holds honorary degrees conferred on him by Texas Christian and Culver-Stockton College.

He formerly served as Professor of Philosophy at Texas Christian University and is a past president of the Highland Broadcasting Company in Radford, Virginia. He has presented lectures at universities throughout this country, Canada, Mexico and the United Kingdom.

He is chairman elect of the Commission on Colleges and Universities, North Central Association, and a past president of the International Convention of Christian Churches (Disciples of Christ).

In 1963 he was one of five recipients of plaques from the Freedoms Foundation Leadership for Public Service in Education.

He is the author of four books.

Program Committee Busy

Several meetings of the Program Committee have been held since the final day of the 1963 annual meeting. The most recent meeting was held in Parkersburg on February 2, and it was announced at that time that arrangements for the 1964 meeting were nearing completion.

In addition to Doctor Gilmore, the other members of the committee are Drs. George F. Evans of Clarksburg, Richard E. Flood of Weirton, Robert D. Crooks of Parkersburg, Seigle W. Parks of Fairmont, and Clark K. Sleeth of Morgantown.

The committee has contacted potential speakers for the three general scientific sessions which will be held on Thursday, Friday, and Saturday mornings, August 20-22. The names of the prominent physicians and surgeons who have accepted invitations to appear as guest speakers will be announced in *The Journal* during the coming months.

Dr. Perry E. Gresham

As usual, meetings of the Association's sections and affiliated societies will be held during the afternoon hours.

Two Sessions of the House of Delegates

The House of Delegates will meet twice during the meeting. The first session will be held on Wednesday evening, August 19, and the second session on Saturday afternoon, August 22.

The pre-convention meeting of the Council will be held on Wednesday afternoon, August 19, and meetings of several committees also will be held at that time.

Auxiliary Entertainment Program

As usual, the entertainment program will be under the direction of the Woman's Auxiliary. The Program Committee has set aside Friday evening for the main entertainment feature for physicians, their wives and guests.

Meetings in West Virginia Wing

General scientific sessions and many of the afternoon meetings will be held in the West Virginia Wing. Industrial and scientific exhibits will be housed in the Exhibit Center in the West Virginia Wing.

Additional information concerning the convention at The Greenbrier will appear in future issues of *The Journal*. The complete program will appear in the issue for August.

American College of Physicians Will Meet in Atlantic City, April 6-10

More than five thousand physicians are expected to attend the 45th Annual Meeting of the American College of Physicians in Atlantic City, April 6-10.

Dr. Robert U. Drinkard, Jr., of Wheeling, is a member of the ACP Board of Governors. His term expires in 1965.

The five days of meetings at Convention Hall will include rounds of scientific education aimed at keeping internists abreast of medical development. The College's annual convocation, featuring the induction of 400 physicians to Fellowship in the College and the conferring of three Masterships and 10 Corresponding Fellowships to physicians of other countries, will be held on Thursday evening, April 9.

Another highlight of the meeting will be the presentation of ACP annual awards to men of distinction in various fields of medical science.

The scientific portions of the meeting will cover topics ranging from gastrointestinal disorders and the diagnosis and treatment of heart diseases to reports on family allergies, infections, lung, liver and kidney diseases, virus problems and conditions involving metabolic function and the endocrine glands.

Highlights of the scientific program include color television presentations on a closed circuit, sessions on basic medical sciences and clinical investigations, panel discussions and hospital clinic sessions.

A public information program, set up through local businessmen, will be held during the meeting. ACP representatives will appear before local service organizations to speak on health problems of particular interest to each group.

Dr. Thomas M. Durant of Philadelphia, Chairman of the Department of Medicine at the Temple University School of Medicine, will be installed as president during the meeting, succeeding Dr. Wesley W. Spink of Minneapolis, Professor of Medicine at the University of Minnesota Medical School.

Spring Congress in Ophthalmology

The 37th annual Spring Congress in Ophthalmology, sponsored by the Gill Memorial, Eye, Ear and Throat Hospital, will be held at the Patrick Henry Hotel in Roanoke, Virginia, April 6-9.

The registration fee is $75 and further information may be obtained by writing Dr. E. G. Gill, 711 South Jefferson Street, Roanoke, Virginia.

W. Va. Acad. Oph. and Otol. To Meet At The Greenbrier, April 15-18

The West Virginia Academy of Ophthalmology and Otolaryngology will hold its 17th annual meeting at The Greenbrier in White Sulphur Springs, April 15-18. Dr. James T. Spencer of Charleston, the President, will preside during the four-day meeting.

John W. Henderson, M. D.

Harold G. Tabb, M. D

Doctor Spencer announced that six out-of-state physicians have accepted invitations to present papers at the general scientific sessions.

The speakers on ophthalmology and their subjects are as follows:

"Traumatic Ocular Surgery," (Two Lectures).—Alston Callahan, M. D., Birmingham, Alabama.

"Medical Ophthalmology," (Two Lectures).—Trygve Gunderson, M. D., Boston.

"Disease of the Orbit," (Two Lectures).—John W. Henderson, M. D., Professor of Ophthalmology, Mayo Foundation, Graduate School, University of Minnesota College of Medicine, and Chairman, Section of Ophthalmology, the Mayo Clinic, Rochester, Minnesota.

The speakers on otolaryngology and their subjects are as follows:

"The Pennsylvania School Program for Hearing Conservation," and "An Ideal School Conservation of Hearing Program."—James M. Cole, M. D., Danville, Pennsylvania.

"Combined Rhinoplasty and Septalplasty (Practical Considerations)," and "Congenital Cysts and Anomalies."—Richard Farrior, M. D., Tampa, Florida.

"The Chronic Ear, Principles and Management," and "Cancer of the Larynx, the Surgical Management."—Harold G. Tabb, M. D., Professor and Chairman, Department of Otolaryngology, Tulane University School of Medicine, New Orleans.

A one-day course on contact lens will be presented by the Plastic Contact Lens Company. The course will be held on Wednesday, April 14, the day preceding the formal opening of the meeting.

Physicians throughout the State have been invited to attend the four-day meeting. A registration fee of $35 will cover all scientific sessions and social functions.

Additional information may be obtained by writing to the secretary, Dr. Worthy W. McKinney, Professional Park, Beckley.

'Travel Meeting' of Ob.-Gyn. Society Planned at WVU Medical Center

The Annual Travel Meeting of the West Virginia Obstetrical and Gynecological Society will be held at the West Virginia University Medical Center in Morgantown, March 19-21.

Dr. Nicholas W. Fugo, Professor and Chairman of Obstetrics and Gynecology at the WVU School of Medicine, said that 14 papers will be presented during the scientific sessions.

Dr. Frederick H. Dobbs of Charleston is president of the Society and Dr. A. J. Villani of Welch the secretary.

The following scientific program will be presented by the faculty of the WVU School of Medicine on Friday, March 20:

"Public Health Problems."—E. W. Chick, M. D.
"Perinatal Problems."—W. G. Klingberg, M. D.
"Erythroblastosis."—Barbara Jones, M. D.
"Amniotomy."—Robert Greco, M. D.
"Respiratory Disorders of the Newborn."—Robert J. Nottingham, M. D.
"Hyperadrenalism."—Bernard Zimmermann, M. D.
"Conservation of Ovaries at Hysterectomy."—Nicholas W. Fugo, M. D.
"Effects of Obstetrical Anesthesia on Newborn."—N. W. B. Craythorne, M. D.
"Cardiac Surgery in Pregnancy."—Herbert E. Warden, M. D.
"Cardiac Disease in Newborn."—Russell V. Lucas, Jr., M. D.

A symposium on "Carcinoma of the Cervix" will be presented on Saturday, March 21. The papers to be presented are as follows:

"Cytology."—Robert R. Chamberlain, Jr., M. D.
"Experiences at West Virginia University Hospital."—Dean Roy Goplerud, M. D.
"The Natural History of Carcinoma of the Cervix."—Victor M. Napoli, M. D.
"Radiation Therapy."—George G. Green, M. D.

Further information may be obtained by writing to Dr. Nicholas W. Fugo, School of Medicine, WVU Medical Center, Morgantown, W. Va.

American Soc. of Internal Medicine Meets in Atlantic City, April 3-5

The eighth annual meeting of the American Society of Internal Medicine will be held at the Claridge Hotel in Atlantic City, April 3-5.

Meetings of standing committees will be held on the morning of Friday, April 3, and the first session of the House of Delegates and meetings of reference committees that afternoon. The second session of the House will be on Sunday afternoon.

The themes of the two general sessions on Saturday and Sunday will be "The Influence of the Medical School and Medical Center on the Practice of Internal Medicine," and "The Effect of Computers on Internal Medicine."

Additional information concerning the program may be obtained by writing the American Society of Internal Medicine, 3410 Geary Boulevard, San Francisco, California 94118.

Charles R. Lewis Joins Staff Of Welfare Department

Charles R. Lewis, veteran Statehouse reporter for the Associated Press, was recently named Executive Secretary to the Advisory Board of the West Virginia Department of Welfare.

The State Senate unanimously adopted a resolution which commended Lewis for his news coverage of its actions during the past 17 years. The resolution was introduced by Dr. Ward Wylie of Mullens, President Pro Tempore of the Senate.

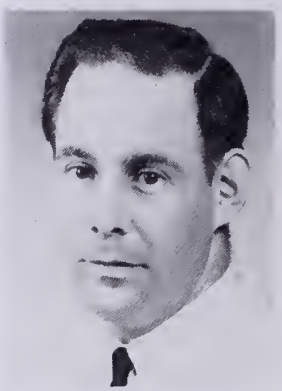
Mr. Lewis is a native of Middleport, Ohio, and was graduated from Ohio University. During World War II he commanded a PT Boat in the South Pacific. He is married to the former Jane Ann Veazey of Charleston and is the father of five children.

Dr. Kenneth G. MacDonald, second from left, receives a past president's plaque from Dr. Joseph A. Smith, the toastmaster, during the Kanawha Medical Society's annual dinner-dance which was held at the Charleston Press Club on January 18. Also shown are Dr. Charles L. Goodhand of Parkersburg, President of the West Virginia State Medical Association, and Dr. George L. Grubb, who succeeded Doctor MacDonald. Winners of plaques for "Meritorious Community Service in the Field of Health," right, are Dr. Peter A. Haley, Mrs. J. Dennis Kugel, Mrs. A. B. Curry Ellison and Dr. Page H. Seekford for the highly successful Sabin Polio program, and Dr. Edwin M. Shepherd for a pilot study of disabled welfare recipients.

2-Day PG Course in Anesthesiology At Medical Center, April 11-12

The annual spring meeting of the West Virginia Society of Anesthesiologists will be held at the WVU Medical Center in Morgantown, April 11-12.

Kenneth E. Penrod, Ph.D.



N. W. B. Craythorne, M. D.

The meeting will be held in conjunction with the third annual refresher course in anesthesiology, sponsored by the Society and the Division of Anesthesiology of the West Virginia University School of Medicine.

One of the guest speakers will be Dr. M. T. Jenkins, who attended the late President John F. Kennedy at Parkland Memorial Hospital in Dallas, Texas, after he was fatally wounded by an assassin.

The Saturday speakers and their subjects are as follows:

"Physiological Aspects of Hyperbaric Oxygenation."—Kenneth E. Penrod, Ph.D., Vice President, Medical Center, West Virginia University.

"Clinical Aspects of Hyperbaric Oxygenation."—C. R. Stephen, M. D., Professor of Anesthesiology, Duke University School of Medicine, Durham, North Carolina.

"Anesthetic Considerations in Carotid Artery Surgery."—Byron M. Bloor, M. D., Professor and Chairman, Division of Neurosurgery, WVU School of Medicine.

"Relationship of the Endocrine System to Surgical Fluid Balance."—Walter H. Moran, Jr., M. D., Assistant Professor, Department of Surgery, WVU School of Medicine.

"Emergency Circulatory Resuscitation." — Peter Safar, M. D., Professor and Chairman, Department of Anesthesiology, University of Pittsburgh School of Medicine, Pittsburgh.

The Sunday speakers and their subjects:

"Post-Operative Management."—N. W. B. Craythorne, M. D., Associate Professor and Chairman, Division of Anesthesiology, WVU School of Medicine.

"Changes in Arterial Oxygen Tension During and After Surgery."—C. R. Stephen, M. D.

"The Anesthesiologist's Role in the Management of Tetanus."—M. T. Jenkins, M. D., Professor and Chairman, Department of Anesthesiology, University of Texas Southwestern Medical School, Dallas.

All interested physicians are invited to attend the two-day meeting and a social hour and dinner dance for physicians and their wives will be held at the Lakeview Country Club on Saturday evening, April 11.

Drastic Changes in Disease Patterns Noted in West Virginia

Remarkable changes in leading causes of death have occurred in West Virginia in less than two decades. State Director of Health Dr. N. H. Dyer noted drastic alterations in disease patterns have come about mainly since the advent of penicillin, which became available for widespread usage in the latter years of World War II.

Writing in his weekly State of the State's Health, Doctor Dyer listed declines in mortality, between 1944 and 1962, ranging from 100 per cent for diphtheria and typhoid (no deaths in 1962) to 15.2 per cent for diabetes (268 deaths in 1962).

Other percentage declines in major categories during the period: maternal death, 78.5; syphilis, 82.9; influenza, 80.5; infant deaths, 54.6; pneumonia, 28.8; polio, 96, whooping cough, 100 (no deaths in 1962); scarlet fever, 88.9; nephritis, 84.5; meningococcal infections, 89.5; measles, 94.8; diarrhea and enteritis, 89.

It was pointed out that these changes were also brought about by other new drugs, improved environmental sanitation, better immunization levels, mass screening and improved patient care. During this period the life span increased about 6.4 years. In 1944, the state had 2,165 infant deaths; in 1962, the total was 982. Some other categories include: tuberculosis, 758 against 146; syphilis, 222 against 38; nephritis, 1,061 against 164; influenza, 323 against 64; diarrhea and enteritis, 326 against 36.

The major problems facing health workers today are heart disease (up 91.3 per cent) and cancer (up 80.3). Another major problem is strokes (up 62.7). Accidents are now the fourth leading cause of death. Pneumonia, influenza, arteriosclerosis, diabetes, congenital malformations, suicide, nephritis and nephrosis were other leading causes in West Virginia during 1962.

Ten New Public Health Programs

In another edition of the department's publication, Doctor Dyer reviewed ten new public health programs scheduled for the state during 1964. These include:

Appalachian Project—a pilot project in a ten county area, to utilize federal grants for the construction of regional public health centers; recruitment, training and a broad expansion of health manpower and resources; and extensive construction of sanitation facilities.

Immunization Program—federal funds will provide for a statewide immunization program for children under five. Surveys underway indicate that as many as half of all residents of the state lack adequate immunizations for diphtheria, whooping cough, tetanus and polio. Plans call for a county-by-county approach in cooperation with local medical societies.

Heart Disease Control—laboratory services for the rapid identification of streptococci will be extended to all physicians in the state and procedures for the distribution of penicillin prophylaxis improved for intensified control of rheumatic fever and rheumatic heart disease.

School Health Education—in cooperation with the State Department of Education to focus on prevention of cigarette smoking.

Home Care for Welfare Clients—a demonstration project for providing a broad spectrum of preventive medical services in one county or welfare district will be conducted with the Department of Welfare in cooperation with practicing physicians.

Air Pollution Study—in the Kanawha Valley will begin in mid-1964 as a joint project with the United States Public Health Service and the Air Pollution Control Commission.

Water Pollution Survey—with the member states of the Ohio River Valley Sanitation Commission and the United States Public Health Service, of problems in the Monongahela River caused by acid drainage from thousands of openings in abandoned mines which must be sealed.

Fluoridation—the state is now fourth in the percentage of persons served by fluoridated public water supplies and a crash program in 1964 will be focused on inclusion of all community facilities.

Research—to better define cultural barriers which prevent public utilization of scientific knowledge through a recently organized departmental research team. Coupled with intensified public health education efforts in 1964, the approach is hoped to result in knowledge and actions toward positive health practices for increasingly larger numbers of people.

Maternal and Child Health—knowledge that birth defects and other such unfavorable outcomes of pregnancies are closely associated with economic and social deprivation form the basis for an intensified program for mothers and children in needy segments of the population. Increased utilization of a recently acquired mobile pediatric clinic will provide for the extension of services to the more remote sections of the state.

Former Gov. Cecil H. Underwood Heads W. Va. Cancer Drive

Former Governor Cecil H. Underwood of Huntington has been named for a second consecutive year as chairman of the American Cancer Society's annual educational and fund-raising crusade in West Virginia.

The selection of the former Island Creek Coal Company vice president was announced by Dr. John C. Condry of Charleston, president of the Society's West Virginia Division. Doctor Condry also announced the selection of Mrs. D. N. Thomas of Weirton as vice chairman.

Symposium on Pediatrics

A Symposium on "Pediatrics-The Sick Child in General Practice," will be held at the Mound Park Hospital in St. Petersburg, Florida, April 9-11.

The course will be limited to 35 physicians, and the registration fee is $40. Further information may be obtained by writing the Mound Park Hospital Foundation, Inc., St. Petersburg, Florida.

Dr. Ross E. Newman New Member Of Medical Licensing Board

Dr. Ross E. Newman of Mullens has been appointed by Governor W. W. Barron as a member of the Medical Licensing Board of West Virginia for an unexpired term ending June 30, 1964.

Ross E. Newman, M. D.

Doctor Newman succeeds the late Dr. Doff D. Daniel of Beckley, who died on February 4. Doctor Daniel had been a member of the Medical Licensing Board since 1949.

Doctor Newman, a native of Dugspur, Virginia, was graduated from Randolph-Macon College and received his M. D. degree in 1933 from the Louisiana State University School of Medicine. He served an internship and residency in surgery at Charity Hospital in New Orleans.

Other physician members of the Medical Licensing Board are Drs. George F. Evans of Clarksburg, the chairman; Frank J. Holroyd, Princeton; D. E. Greenelteh, Wheeling; W. P. Bittinger, Summerlee; Everett H. Starcher, Logan; and N. H. Dyer, Charleston, secretary.

Dr. Holroyd Named State Chairman Of World Medical Committee

Dr. Frank J. Holroyd of Princeton has been named State Chairman for The United States Committee of the World Medical Association.

Doctor Holroyd, a past president of the State Medical Association and currently a delegate to the AMA, will be responsible for directing programs and activities of the U.S. Committee in the State.

Dr. Edward R. Annis, President of The American Medical Association, is currently President of the World Medical Association. The Chairman of the U.S. Committee of the Association is Dr. Austin Smith, President of the Pharmaceutical Manufacturers Association.

Dr. W. V. Wilkerson Honored

Dr. W. V. Wilkerson of Whitesville was installed as Governor for West Virginia of The American College of Cardiology during the recent annual meeting of the College which was held in New Orleans.

Relocations

Dr. R. O. Pletcher, who had practiced in Lost Creek since 1940, has moved to Patton, California, where he is serving a three-year residency at the Patton State Hospital.

Dr. Norman A. Welch Will Speak At Wheeling Jaycee Banquet

Norman A. Welch, M. D.

Dr. Norman A. Welch, of Boston, president elect of the American Medical Association, will be the guest speaker at the Wheeling Junior Chamber of Commerce "Citizen of the Year Banquet" at Wilson Lodge on March 5.

Doctor Welch, a member of the AMA House of Delegates since 1951 and who served as speaker for four years, will be installed at the 113th annual meeting in June at San Francisco. He will succeed Dr. Edward R. Annis of Miami, who assumed office last June in Atlantic City.

Dr. William J. Steger of Wheeling will be one of the 12 Ohio Countians honored by the Jaycees at the banquet.

The Ohio County Medical Society will honor Doctor Welch with a reception prior to the banquet.

Medical Meetings, 1964

The following is a partial list of national, state and district medical meetings scheduled for 1964:

Mar. 6-7—National Conf. on Rural Health, Columbus, Ohio.
Apr. 6-10—ACP, Atlantic City.
Apr. 13-16—AAGP, Atlantic City.
Apr. 15-18—W. Va. Acad. Oph. and Otol., White Sulphur Springs.
Apr. 15-18—W. Va. Chapter, ACS, The Greenbrier, White Sulphur Springs.
May 1-2—W. Va. Soc. Med. Technologists, Parkersburg.
May 15-17—W. Va. Chapter, AAGP, Charleston.
June 21-25—AMA Annual Meeting, San Francisco.
Aug. 20-22—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 4—W. Va. Heart Assn., Huntington.
Oct. 1—Rural Health Conf., Jackson's Mill.
Oct. 23-25—American Heart Assn., Atlantic City.
Nov. 16-19—Southern Medical, Memphis, Tenn.

Quality of Testing New Drugs

The medical profession must assume a degree of responsibility for informing itself about laws and regulations under which it must function, about special problems arising from special drugs, and about the existence and potential value of new drugs.

Professional and scientific societies through appropriate committees can play a significant role in accomplishing these objectives. Moreover, such committees might well address themselves to the important problem of the quality of clinical testing of drugs in various clinical fields of medicine.—Thomas B. Turner, M.D., Dean, Johns Hopkins University School of Medicine.

W. Va. Heart Association Has Funds Available For Research Work

The West Virginia Heart Association is now accepting applications for research grants in the field of cardiovascular disease. Grants are not restricted to any particular discipline although the investigator must be qualified and have available facilities necessary to pursue his investigation.

Individual requests for grants should not exceed $3,000 although no maximum has been established by the Association's Research Committee. Awards will be based on merit, need and available funds.

All requests for the 1964-65 fiscal year should be submitted by April 15. Application blanks and additional information may be obtained by writing to the Research Committee, West Virginia Heart Association, 759 West Washington Street, Charleston, West Virginia 25302.

ACP Course in Atlantic City

The American College of Physicians will sponsor a postgraduate course on "Current Concepts in the Physiology of Respiration, Circulation and Electrolytes," at the Hotel Dennis in Atlantic City, April 2-4.

The three-day course will be devoted to summarizing physiologic information for the practicing physician. It will be concerned with providing an authoritative and precise summary of the current status of knowledge of physiologic processes in the respiratory system, the circulatory system and the electrolyte metabolism.

The registration fee for ACP members is $60 and $100 for non-members. Further information may be obtained by writing Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Ob. and Gyn. Examinations

The American Board of Obstetrics and Gynecology has announced that Part II Examinations, oral and clinical, will be conducted at the Edgewater Beach Hotel in Chicago, by the entire Board, April 27-May 2. Formal notice of the time of examination will be sent to each candidate in advance of the examination dates.

Further information may be obtained by writing the Secretary, Dr. Robert L. Faulkner, 2105 Adelbert Road, Cleveland 6, Ohio.

PG Course in Cleveland

A postgraduate course on "Hypertension: Mechanisms, Diagnosis, and Treatment," will be presented by the Cleveland Clinic Educational Foundation in Cleveland, March 18-19.

The registration fee is $30 and further information may be obtained by writing to Education Secretary, The Cleveland Clinic Educational Foundation, 2020 E. 93rd Street, Cleveland, Ohio 44106.

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April, 1964 Vol. 60, No. 4

Changing Concepts of Angiography

Joseph L. Curry, M. D., Willard J. Howland, Jr., M. D., Andrew K. Butler, M. D., Charles T. Lenton, Jr., M. D., And Zoltan Szalontay, M. D.

The concept of using a rapidly injected liquid contrast medium in order to visualize by x-ray the interior of the cardiovascular system is not new. The first renal arteriogram was made in 1896 (one year after discovery of the x-rays) on a post-mortem specimen and demonstrated surprisingly excellent detail.[1]

Dr. Werner Forssman, in 1929, inserted an oiled urethral catheter in his own brachial vein and advanced it until its tip entered his heart. At the time, Forssman's colleagues scoffed at his efforts and refused to participate in his investigation. Forssman thus found it necessary to carry out the procedure himself and injected a contrast medium via the catheter, at which time x-rays of his cardiac chambers were procured. Forssman's investigation represented one of the many pioneer procedures which formed the groundwork for tremendous advances in cardiovascular radiology. In October, 1956, Forssman shared the $38,700 Nobel Prize for Medicine and Physiology entirely as the result of his initial convictions and intense investigations.

Although various surgical approaches for arteriography were devised early, the advent of x-rays of good diagnostic quality and produced at rapid time intervals was delayed until the development of modern electronic equipment. Moreover, contrast media of high density and relatively low toxicity and viscosity had to be originated.

Figure 1 schematically illustrates the more common sites of needle puncture of the cardiovascular system in order to inject a contrast medium. Many of these sites have become extremely popular because of their accessibility, also because of the high incidence of local disease that lends itself to diagnosis by this means.

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Such formidable puncture sites as the ventricles of the heart and the aortic arch have been practically abandoned, largely because of the risks involved, among which are included coro-

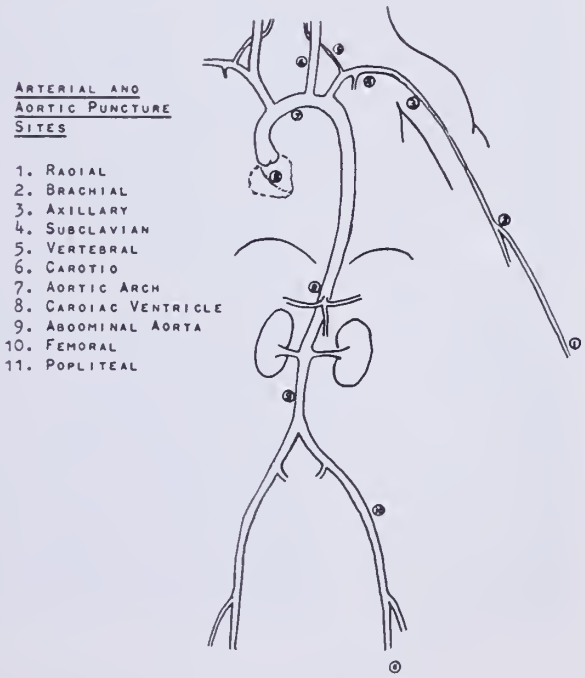

Figure 1. Schematic arterial tree—See text.

Submitted to the Publication Committee, December 5, 1963.

nary artery puncture and uncontrolled bleeding. Nevertheless, many direct cardiac and suprasternal aortic punctures have been accomplished in this country in recent years, with a relatively low incidence of complications.[2, 3]

It should be noted that the wide field of angiography embraces two principal components. First, detailed visualization of the blood vessels themselves and, second, dynamic study of circulatory patterns of various organs provided by serial x-rays taken during arterial, capillary and venous phase. The former is well illustrated in terms of detailed study of vascular occlusive disease while the latter is best appreciated in evaluation of such entities as "tumor stain" in brain studies and nephrogram patterns of renal cysts and tumors, and of chronic pyelonephritis. Many other similar examples in other body organs could be cited.

Direct needle puncture of the aorta as well as of the carotid, brachial, axillary and femoral arteries, has become common practice and permits precise diagnosis not previously available.

A New Technique

A new approach to intravascular and intracardiac radiology was devised by Seldinger,[4] of Sweden, who, in 1953, published a description of his technique. It consists of threading a plastic catheter over a thin intravascular wire. Using fluoroscopy, the opaque catheter can then be directed to a large number of intracranial, thoracic and abdominal locations where specific arteries may be selectively injected. With this method, the femoral and axillary arteries have become the most popular sites for insertion of catheters in the vascular system. Similarly, venous anatomy also has been rather widely studied in recent years. Special techniques that now are becoming available permit visualization of major lymph vessels and lymph nodes (lymphangiography). At present, lymphangiography is technically rather difficult and time-consuming, although it affords extremely valuable information in selected cases, with special reference to evaluation of neoplastic disease and its metastases.

Ten Years of Angiography

During the past ten years, 1,246 angiographic procedures were performed in the Department of Radiology of the Ohio Valley General Hospital, Wheeling, West Virginia.

In the early part of 1963, a rapid pressure injector of advanced design (Cordis Injector) was acquired and greatly broadened the scope of our arteriography work, with particular reference to retrograde arterial studies and high opacification aortography. Demand for these studies has recently increased considerably, with a present monthly average exceeding 40 cases (Table 1).

The technical procedures are performed by radiologists or surgeons, catheter studies being performed almost exclusively by radiologists.

Femoral Arteriography

Femoral arteriography is indicated in many patients with vascular insufficiency of the lower limbs. The procedure consists of insertion of a

Table 1

	Jan. (63)	Feb. (63)	Mar. (63)	Apr. (63)	May (63)	June (63)	July (63)	Aug. (63)	Sept. (63)	Oct. (63)	Nov. (63)	Dec. (63)	Jan. (64)	Totals
CAROTID ARTERIOGRAM (Direct Needle)	12	1	9	13	16	15	9	5	11	5	8	3	7	114
RIGHT RETROGRADE BRACHIAL (Cannula)					1	1	1	2	4	9	6	4	6	34
RIGHT RETRDGRADE AXILLARY (Cannula)									3	1	4	3	3	14
LEFT RETROGRADE BRACHIAL (Cannula)									1					1
THORACIC ADRTOGRAM (Catheter)	1	2	2	1	2	1	2	2	5	9	8	9	6	5D
CAROTID VIA FEMORAL (Catheter)	1				1				1	1	1	4	4	13
CAROTID VIA AXILLARY (Catheter)										2	1			3
ABDDMINAL AORTOGRAM (Catheter)	1	1					4	4	1D	7	10	11	14	62
SELECTIVE RENAL ARTERIDGRAM (Catheter)		1					1	1	3	2	3	5	6	22
ABDOMINAL AORTDGRAM (Direct Needle)		1		2	1	2	2	2		3		1	1	15
ANGIDCARDIOGRAM (Cannula Intravenous)	1													1
SPLENOPORTOGRAM (Direct Needle)			1		1		1			1				4
LYMPHANGIDGRAM				1				1	1				1	4
FEMDRAL ARTERIOGRAM (Direct Needle)	2		1	3	4	2	2	3	3	1	1	2	1	25
VENOGRAPHY (Direct Needle)	1	1	1		1		2		3					9
TDTALS	19	5	14	2D	27	21	24	20	45	41	42	42	49	371

ANGIDGRAPHY PROCEDURES, JANUARY, 1963 THROUGH JANUARY, 1964.
DHID VALLEY GENERAL HOSPITAL, WHEELING, W. VA.

percutaneous needle or cannula in the femoral artery at a point near its origin, with direct injection of opaque material. The best films are obtained by a scanning technique following radioisotope timing by a method originally developed in this department.[5] The method makes possible an excellent demonstration of vessels distal to obstruction. Similar studies of the upper extremity are made by injection into the axillary or brachial artery (Figure 2).

Thoracic aortograms most frequently are performed for evaluation of the brachiocephalic vessels. By this means, aortic aneurysm also can be differentiated from other mediastinal masses. For this examination, a catheter is introduced, usually into the femoral artery, by the percutaneous Seldinger technique and the catheter tip placed in the ascending aorta. Opaque medium is then delivered by means of a pressure injector. The catheter may be introduced also into either axillary artery and placed in the ascending aorta for this examination. This appears to be the most physiologic method for demonstration of extracranial occlusive disease.[6] Detailed study of these major vessels can be obtained (Figure 3).

Abdominal aortograms can be accomplished either by the translumbar or the catheter route. Introduction of a catheter into the abdominal aorta via the femoral or axillary artery seems to be a safer and easier method because the arterial puncture site is accessible for manual pressure to control bleeding. If there is extensive occlusive disease of the lower aorta or the iliac vessels, the axillary approach is easier and safer.

Other Procedures

Right brachial arteriography has been popularized by Marshall and Ling and their coworkers.[7] It offers a quick and convenient method of evaluating the intracranial vessels. By this means, the right carotid system is filled as well as the right vertebral and basilar systems. The right brachial artery is cannulated with a large percutaneous needle and contrast material injected by means of a pressure injector so that the right brachial, axillary and subclavian arteries act as a catheter to carry dye into the carotid and vertebral systems. Introduction of this same needle into the axillary artery can serve the same purpose when brachial arteriography is not feasible. It also allows catheterization of the

Figure 2. Extensive arteriovenous malformation involving lateral aspect of left hand. Note early voluminous venous drainage. One second interval film procured after rapid injection of contrast medium in the axillary artery.

Figure 3. Normal aortic arch and brachiocephalic arteries. Catheter advanced into aortic arch after a percutaneous femoral artery insertion. Contrast medium injected in one second at a pressure of 500 lbs. per sq. in.

axillary artery for other studies, when indicated. The brachial artery probably should not be catheterized, because of the possibility of continued spasm. It is very important that a needle not be left in the brachial artery over prolonged periods and when using this approach we arbitrarily limit the time of the procedure to 35 minutes.

Aorta Visualized

Left brachial arteriography allows visualization of the aorta and its main branches by cannulating the left brachial artery and using this system as a catheter to the aorta. This has been rarely indicated in our experience and we generally prefer to introduce a catheter into the left axillary artery and selectively place this where indicated.

For Intracranial Pathology

Catheterization of the carotid and vertebral vessels offers an exciting new method for study of intracranial pathology without introducing a needle into these brain-supplying arteries and inviting the trauma, spasm and hypotension which may occur with needle puncture. This may be done via the femoral artery approach or, in many instances, via the brachial artery. Figure 4 shows selective catheterization of the left common carotid artery via the right axillary artery. Figure 5 shows selective catheter arteriography of the right common carotid artery in a three-year-old.

Selective renal arteriography often is indicated in situations involving renovascular hypertension. Injection through a catheter in the abdominal aorta is done as a preliminary procedure but may be inconclusive. Catheterization of the artery allows definitive study of the renal vasculature. Selective renal arteriography is indicated also in the differential diagnosis of renal cysts and tumors. Identification of tumor vessels is just as precise as in cerebral arteriography (Figure 6). By this procedure pyelonephritic atrophy can be differentiated from congenital hypoplasia. The entire subject will be the basis of a future communication.

The Vena Cava

Superior and inferior vena cavograms occasionally are of value in a more definitive study of mediastinal and retroperitoneal masses. These procedures usually are performed by direct

Figure 4. Selective left common carotid arteriogram. Catheter tip placed in carotid orifice after percutaneous insertion in the right axillary artery.

Figure 5. Selective right common carotid arteriogram in a three-year-old male. Catheter tip advanced into the carotid artery after percutaneous insertion in the left femoral artery.

Figure 6. Selective left renal arteriogram in a 50-year-old male showing large cystic carcinoma. Note abnormal vessels indicative of tumor.

needle puncture of the contributing veins, with manual injection of contrast material. Splenoportograms are specialized venographic procedures which allow detailed studies of portal hypertension and are easily performed following direct puncture of the spleen, with injection of contrast material.

Almost all procedures are done under local anesthesia following demerol and phenergan premedication. This provides for excellent patient cooperation, with low morbidity from the process. At its completion, in all cases, a clinical summary is made, one copy of which is placed on the patient's hospital chart and one in the film folder.[8]

Complications

Lang[9] has recently reported a survey of 11,402 arteriograms (including aortograms) revealing only 7 deaths and 81 serious complications. A large number of complications were related to faulty technique and inexperienced operators. Complications related to the contrast medium were rare. We have seen adverse permanent sequelae only after direct needle puncture carotid arteriography. Temporary loss of vision is an alarming complication which we have encountered in catheter arteriography.[10]

It must be emphasized, therefore, that these diagnostic procedures are potentially hazardous. Serious complications include thrombosis with secondary loss of limb, embolization by a broken catheter tip, perforation of the heart or major vessels and renal or bowel necrosis. Necrosis may occur as a result of toxic reaction to the contrast medium or mechanically induced vascular occlusion.

Such procedures should be limited to institutions which are well equipped and which are staffed by well-trained radiologists.

Finally, we are convinced that the services of a surgeon skilled in vascular surgery should be immediately available whenever angiographic procedures are performed.

Summary and Conclusions

The purpose of this paper is to emphasize the increasing importance of angiographic procedures in the precise diagnosis of disease entities. The procedures frequently provide information which cannot be obtained by any other means. They should be reserved for well equipped departments of radiology staffed by physicians well acquainted with such techniques.

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Duodenal Ulcer and the Success of Therapy*†

J. C. Handelsman, M. D.

The success of a given form of therapy determines its general acceptance, and this is as it should be. This is, after all, a restatement of the obvious: that the aim of medicine is cure. The judgment of success, however, depends on the target. When a disease process lends itself to surgical removal, as in the case of appendicitis, mortality is the criterion which determines whether or not one elects to operate. When, however, we are treating a disease which is of obscure etiology and which is ill adapted to any type of direct attack physiologically—a disease process such as duodenal ulcer—evaluation of therapy is far less clear cut. A complex comparison, weighing mortality, morbidity and recurrence rates, and requiring a strict definition of terms, is necessary before one or another form of therapy can be accepted completely.

Historically, almost every type of treatment for duodenal ulcer has achieved enormous success. As the dreary procession of new procedures has come past, each in turn has promised the golden answer to all problems. Such confusion cannot be due to lack of honesty nor to naive, premature enthusiasm for each new form of treatment. It arises primarily from failure to define properly the aims of therapy and, secondarily, from failure to differentiate between therapy extended for cure of ulcer and therapy extended to cope with the effects of ulcer.[1]

Obviously, the aim of treatment for duodenal ulcer is to get rid of the ulcer or, failing that, at least to remove the effects of the ulcer. All treatment programs today, be they so-called medical or surgical, are designed to accomplish this by control of gastric hydrochloric acid, either by aborting its production or by halting its effect on the mucous membrane. It is accepted, as the result of clinical experience and laboratory experimentation and, specifically, following the documentation by Dragstedt, that an exaggerated phase of cephalic secretion is the factor most responsible for the production of an ulcer and its damage. Table 1 illustrates the fundamental observations of Dragstedt[2] in this regard.

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Table 1

(After Dragstedt)

Distribution of The Phases of Gastric Secretion In The Ulcer Patient

Nervous (Cephalic)	80%	
		Fasting nocturnal secretion is 3 to 4 times normal Stimulation yields 2 times normal acid secretion
Antral (gastric)	15%	
Intestinal	5%	

First, the fasting nocturnal secretion of hydrochloric acid in a duodenal ulcer patient is three to four times that secreted normally. This acid appears, of course, when the patient is most vulnerable to damage, i. e., when the stomach is empty.

Second, stimuli to acid production are twice as effective in the ulcer patient.

Finally, the nervous or cephalic phase of secretion accounts for 80 per cent of the secretion in the duodenal ulcer patient, the antral phase accounting for only 15 per cent and the intestinal phase for 5 per cent. This is not a mere academic exercise, as is readily demonstrated by the great and favorable influence on ulcer disease exerted by measures controlling the nervous or cephalic phase of secretion.

Categories of Management

Traditionally, therapy for duodenal ulcer falls into the two large categories of management: medical and surgical. While it is highly tempting to draw comparisons between medical and surgical management, such comparisons are unrewarding and contribute little to an understanding of the problems involved in treatment. The two

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†From the Department of Surgery—The Johns Hopkins University School of Medicine and Hospital.

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categories are not competitive nor do they treat the same disease.

Harkins[3] describes a gradient of duodenal ulcer severity with the distribution of surgical and medical treatment. Only the 30 per cent of patients most seriously afflicted are ever considered candidates for surgery.

Although one might take issue with the distribution of percentage of cases treated medically as opposed to those treated primarily surgically, generally speaking, those patients submitted to surgical therapy are those with the more severe ulcer disease. It is indeed the severity of the disease and the complications thereof which have made them candidates for surgery by the classical criteria. And, equally true, the vast majority of individuals with duodenal ulcer do not become surgical patients.

Assessment of Medical Therapy

How successful is medical management? With what assurance can this large group of ulcer sufferers contemplate cure, or immunity from the effects of ulcer? Most of these patients (90 to 95 per cent) experience prompt symptomatic relief. Ordinarily, the ulcer heals in six to eight weeks.

Althausen,[4] however, aggregated series which demonstrated that in 46 to 93 per cent of cases the patient on medical therapy will experience recurrence in five years or less. Characteristically in such studies, it is also shown that these recurrences are uniformly distributed in time over the period of the study. By implication, therefore, successful ulcer therapy, keeping the patient free of symptoms or recurrence over a one-year to three-year period, does not guarantee that the ensuing year or two will continue to show the same gratifying result. The average recurrence seems to take place about every two years. So much for "cure."

If one attempts to analyze the success of medical treatment in terms of freedom from the effects of ulcer rather than in terms of cure, an interesting figure is derived from the observations of Brooks and Moore.[5] Their survey of the long-term experience at Massachusetts General Hospital indicates that after undergoing medical treatment approximately 18 per cent of patients were economically incapacitated, or were dissatisfied, and that an additional 13 per cent came to surgery.

Meaningful mortality figures for medical treatment of duodenal ulcer are difficult to establish with certainty. While Brown[6] reported 3.3 per cent, Kantor[7] 2.7 per cent, and Brooks and Moore refer to a 2 to 4 per cent long-term mortality with or without surgery, these figures tend to be high, failing to include the vast ambulatory population of mild ulcer sufferers who never enter a statistical study because of self-treatment, or private treatment on an outpatient basis. The one great advantage accorded the physician in this discussion is that the attrition is spread out—not concentrated in the dramatic series of events centered in and about a surgical procedure.

In summary then:

(1) Medical therapy is extended the large majority of duodenal ulcer sufferers.

(2) with
- (a) prompt symptomatic relief
- (b) usual healing in 6-8 weeks

(3) but
- (a) approximately 80 per cent experience recurrence
- (b) averaging every 2 years

(4) and
- (a) 13 per cent come to surgery
- (b) while an additional 18 per cent remain dissatisfied

(5) and

2 to 4 per cent of duodenal ulcer sufferers die over long-term follow-up with or without surgery.

We proceed to a consideration of the place and value of definitive surgery in the treatment of duodenal ulcer:

It has been mentioned that some 12 to 15 per cent of duodenal ulcer patients eventually are submitted to operation. This experience is shared by the Mayo Clinic,[8] by us at Hopkins, and by Moore.[5] As we know, it is the complication of the ulcer that brings the patient to this situation. It is the hemorrhage, the obstruction, the perforation, or the failure of symptoms to come under control for a variety of reasons.

The surgeon is immediately confronted with a disease which has shown itself to be severe, life threatening and resistant. Shall he decide to save the patient's life by dealing merely with the emergency—suturing the bleeding vessel? relieving the obstruction? closing the perforation? Or shall he add to this the surgical measures needed to cure the ulcer completely? Experience dictates that surgical efforts to take a life-saving short-cut too often will end disastrously unless supplemented by a definitive surgical attempt to cure the ulcer.

Two Basic Types of Procedure

Since it is manifest that the indications for surgery come from categories of widely different problems, from the threat of hemorrhage to the more casual persistence of pain, it is only reasonable that results be compared within the same categories.

Any surgical approach to the cure of duodenal ulcer today involves one of two basic types of procedure. The first is subtotal gastrectomy, an effort to remove a sufficiently large portion of the stomach so that the amount of acid secreting mucous membrane left behind cannot be sufficiently great to permit recurrence or to react adversely under acid-stimulating provocation.

The second type is vagus section combined with so-called drainage. This operative approach has as its aim elimination of the nervous or cephalic phase of secretion. Based on knowledge of the preponderance of this secretion in the ulcer patient, a salutary effect on the ulcer is anticipated with its elimination. The unfortunate side effects of vagus section are gastric atony and retention. Left untreated, these must inevitably lead to enhancement of the gastric phase of secretion and thereby to a high incidence of recurrence. It therefore is necessary to combine with vagus section some mechanism whereby the stomach may empty efficiently and promptly, but passively, during its atonic phase. This is accomplished through elimination of the pylorus as an effective sphincter (pyloroplasty) or through passing the food out of the stomach proximal to the pylorus (gastroenterostomy). Whatever the indication, surgical cure of the ulcer demands application of one of these two acid-controlling operations.

It is increasingly widely felt today that small (50 to 60 per cent) resection combined with vagus section provides equal success with less undesirable morbidity. Ferguson[9] finds that comparable series disclose a greater per cent postoperative weight gain, more consistent anacidity, less dumping and more favorable results if he resorts to the former operation.

In answering the questions regarding surgery, I should like to make reference to two groups of figures, to anticipate a criticism. The first group is from university centers, group figures implying shared views and responsibilities. The second represents results in private practice of certain individual surgeons: Watson,[10] of Pittsburgh, Stafford and Finney,[11] of Baltimore, and the writer.

Table 2

Surgical Mortality From Hemorrhage

	AUTHOR	HOSPITAL	YEARS	CASES	MORTALITY
General Criteria for Surgery	Kozoll-Meyer	Cook County	1935/55	2008	19%
	Nyhus	Kings County Seattle	1955/57	410	24%
	Elliot	Ohio State	1950/62	417	19%
Specific Criteria for Surgery	Stewart	Buffalo	1947/55	193	13%
	Dennis	Kings County New York	1952/57	130	14%
	Spicer	San Francis. Gen.	1956/61	196	20%

Discussion

Let us consider, first, hemorrhage. The aggregated series disclose a mortality rate of 13 to 24 per cent. The private series had a mortality rate of 5 to 7 per cent. But these figures have no great significance. Reference to the report by Dennis and his co-workers[12] on their recent study of 130 cases will show that in 58 cases in which no surgery at all was performed, there was a mortality rate of 14 per cent. Thirty-seven cases submitted to operation immediately had a mortality of 14 per cent; 35 cases submitted to surgery under the selective criteria of Stewart and a mortality of 14 per cent.

We must conclude, then, that hemorrhage from ulcer may be met successfully in different ways, consistent in that all of them meet the problem in the manner which has been found most satisfactory in that surgeon's or clinic's setting.

There is only one question to be answered: Will the patient bleed again? Since this cannot be answered, we must not individualize as to patient.

II. Obstruction. Of all criteria for the institution of surgery, obstruction is the easiest to assess. The clinical syndrome can be clearly delineated by the patient's behavior and an x-ray evaluation. The urgency is limited in that the threat to life is not immediate. The indication for surgery is not absolute in that there are a distinct number of patients who can be improved by a period of medical management. This permits the bringing of that patient requiring surgery to operation under relatively optimal circumstances as compared with those prevailing in perforation or hemorrhage.

In view of the fact that a large number of these patients have stenosis from contracture of old scar tissue, an opportunity is afforded the surgeon to complete a procedure which will relieve the obstruction and concurrently cure the ulcer.

Relief of the obstruction proper is essentially a mechanical problem and therefore lends itself readily to surgical relief. The results here are the most gratifying of the whole surgical endeavor in the field of ulcer therapy. If the surgeon employs vagotomy with a drainage procedure he will automatically relieve the obstruction at the constricted pylorus. If one elects to carry out subtotal gastrectomy, resection of the stenosed area automatically provides relief of the obstruction. Absence of the overwhelming pressure to make haste because of hemorrhage or because of peritonitis permits the more leisurely procedure which will assuredly effect a cure. Here indeed results approach the ideals which will be discussed under the consideration of intractability.

III. Perforation. Perforation most closely approaches the absolute indication for surgery. As is well known, simple closure of a perforation is frequently a life-saving procedure. It has been demonstrated, however, in numerous series from European countries, primarily France and the Eastern countries, and substantiated in numerous American series, including those of Cooley and De Bakey, in Houston, that it is possible to carry out a definitive ulcer procedure in the face of an acute perforation with the same degree of safety as that prevalent in simple closure of the perforation. Generally speaking, prevailing attitude is that if all other things are equal, resection may be done with the same risk as simple closure. In these circumstances one may expect a salvage rate from the immediate catastrophe of perforation as the order of 96 per cent. The eventual results of the surgery with regard to cure of the ulcer will be entirely as expected were the surgical therapy undertaken on an elective basis.

IV. Intractability. Intractability is a loose heading and difficult to define. It includes the patient under financial stress who cannot afford to stay with his diet, the chronic alcoholic, the patient of subnormal mentality, the patient who under optimal treatment has continued to have symptoms or in whose case recurrence has developed. In this patient election to operate is always consultative. Time is rarely a factor in reaching the decision. The operation is decided upon and carried out under optimal circumstances. Patients with varying degrees of virulence of the disease as well as varying periods of duration are operated upon in this category. In these circumstances what can one expect in terms of results? Brooks and Boore, in 1959, delineated their expectancy on the basis of the experience in Boston at a 2 to 4 per cent mortality rate which in their view is the mortality rate of ulcer with or without surgery over the long period of time. Surgical failures are 5 per cent. Waters described a 4 to 5 per cent recurrence rate with surgery.

Indicative of private practice of a high level of skill again are the figures of the private series, with a mortality rate of less than 2 per cent and cure completely comparable with that of any university center. Stafford and Finney report one death in a group of 196 patients operated upon in this indication, and 85 per cent satisfactory results. In only 3 per cent of their group was the result judged poor. Harvey,[14] in reporting the follow-up in the Presbyterian Hospital, was able to describe 7,579 patients who had undergone operation with eminently satisfactory results.

Summary of Surgical Efforts

We are discussing uniquely complicated ulcer cases and must therefore limit ourselves to categories of complications.

(1) Hemorrhage. A high (7 to 14 per cent) mortality rate prevails. What one does seems less important than that he do it consistently. Do not individualize.

(2) Obstruction. Results are superb, and the disease is lenient.

(3) Perforation. Results are good. Resection is as safe as simple closure.

(4) Intractability is the truest challenge to surgical treatment of ulcer. Failure rate is 5 per cent.

Gastric Hypothermia and Hemorrhage

The discussion would be incomplete without reference to the role of gastric hypothermia in controlling hemorrhage.

The experience recently reported by Kelley and his colleagues[15] is typical. Hypothermia reduces by half the number of patients requiring emergency surgery for bleeding. The mortality rate for the total group was lower than that for surgery alone. Cooling did not seem to deny the use of surgery if it failed. On this basis, it is not surprising that cooling is more and more enjoying a firm position in the healing of ulcer.

The knowledge that an appreciable period of time must elapse before an opinion of a definitive therapy has meaning lends hesitancy in commenting on freezing as a definitive therapy. It is receiving a wide trial in a diversity of settings and for a number of indications. At Hopkins the experiments on animals have dictated reservations regarding clinical trial.

In conclusion, how can the success of treatment for duodenal ulcer be improved? Moore

feels that "the nicety of future ulcer care lies in undertaking definitive surgery in the right cases before enough failures have accumulated to justify the term "intractable." This is a diagnostic problem, a problem in making the diagnosis of a progressive, virulent ulcer disease."

When surgery for duodenal ulcer is extended under reasonable circumstances, as we have seen, the mortality rate is the same as that for medical therapy, and the success is greater. This means that the problem really is to keep the patient from reaching the dangerous zone in the spectrum, to which we referred earlier.

No therapy based on newer knowledge of etiology is on the horizon. Improvement therefore must come within the framework of what is known. One answer to this is surgery itself. With a success of 95 per cent, early application of surgery to the young man, the single hemorrhage case, the patient who has perforated, will prevent his reaching the bleak zone of the spectrum with its discouraging level of success. These are the cases which we know will get into trouble.

Good early modern surgery lies at the beginning of good modern successful treatment of duodenal ulcer.

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Listen

ALTHOUGH we are living in the age of the spoken word (since the development of the vacuum tube and the transistor) there is sometimes a question of the value of the words we hear. The language of the comic book, Madison Avenue, and the political word-twisters has dulled our auditory reflexes so they no longer easily differentiate meaningful and precise phrases from senseless and formless verbiage.

As a reaction to this era of the myopic metaphor we may tend to suppress our conscious receptors, and fail to grasp some of the diagnostic "pearls" cast before us by our patients while we are taking their history. The careful history is still the most important of our diagnostic tools, and before we rush for the laboratory studies it is well to remember the teachings of the famous surgeon, John Benjamin Murphy, who admonished his students to:

"Listen, listen to the patient's story. He is telling you the diagnosis."—Robert F. Lorenzen. M. D., in Arizona Medicine.

Current Management of Coronary Heart Disease*

James W. Woods, M. D.

Early diagnosis and improvement in management of coronary heart disease (CHD) deserve our best efforts. A significant decrease in mortality, however, will depend upon prevention. One among several reasons is that the immediate mortality (sudden death) rate of the first attack has remained at around 30 per cent in most reported studies.

Management of the acute myocardial infarction and its complications will be considered first. The confused state variously labeled coronary insufficiency, status anginosus, and preinfarction angina will be omitted in accordance with Proger's[1] recommendation that CHD be classified as acute, with or without infarction and chronic, with or without manifestations. The latter is justified primarily because of the differences in risk and management of the acute and chronic forms. The recommendations set forth below represent the preferences (and prejudices) of the author.

A. Acute CHD With Infarction

1. Relief of pain. Sydenham, in 1680, wrote, "Among the remedies which it has pleased Almighty God to give to man to relieve his suffering, none is so universal and so efficacious as opium." This still is true. Morphine is unequalled as an analgesic. The optimal dose is 10 mg. (15 mg. is no more effective) and normally should be given subcutaneously. In the presence of shock, however, the intravenous route should be used. Meperidine hydrochloride is popular today but is more expensive; it also may lead to respiratory depression and addiction. Nitroglycerin may be safely used for angina pectoris during convalescence but should not be used in the first days after infarction because of its hypotensive effect.

2. Oxygen is valuable if dyspnea is present but is of dubious value for pain relief. The two-pronged, disposable, nasal cannula is a comfortable means of achieving around 53 per cent concentration at a 10 liter flow if the nose is open and the patient will breathe through it. At similar flow rates, the nasal catheter will achieve approximately 60 to 70 per cent concentration and the tent around 50 per cent. The latter, of course, has an advantageous cooling effect in the absence of air conditioning. A completely satisfactory method of humidifying oxygen delivered by small tube or catheter has not yet been evolved.

3. Bed rest. The period has been gradually shortened to three weeks for the uncomplicated case in most hospitals and more liberties (chair, bedside commode) allowed. This has not adversely affected mortality nor morbidity and may have reduced them.

4. Anticoagulants. It is our opinion that in all cases of acute infarction in which there is no contraindication, the patient should receive one of the oral anticoagulants during hospitalization. Warfarin sodium has the advantages of more rapid onset, more predictable response and fewer escapes from therapeutic effect. Aqueous heparin may be given subcutaneously on a 6-hour (75-100 mg.) or 12-hour (150-200 mg.) basis for the first 48 hours while awaiting the oral anticoagulant effect but it is probably unnecessary. If the patient is reliable, the physician familiar with the use of anticoagulants on an ambulatory basis, and the laboratory reliable, the drug may reduce the threat of recurrent infarction for the first 6 to 12 months.[2] The matter of long-term anticoagulation for the prevention of myocardial infarction is unsettled, and there are no well controlled studies which show benefit beyond one year. Discontinuance of anticoagulants probably should be gradual rather than sudden because of suggestive evidence of a rebound effect.[3, 4]

5. Cardiac monitoring during the first 2 to 3 days for prompt detection of arrhythmias or cardiac arrest is advantageous where telecardiographic or oscilloscopic equipment is available. Fibrinolytic therapy remains experimental. Mild

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sedation with phenobarbital for the restless patient often is helpful.

B. Complications

1. Cardiac arrest. In as high as 26 per cent of cases, the patient with CHD dies suddenly with an intact myocardium.[5] Even in cases of acute infarction, resuscitation and long-term survival are possible in a significant number. These facts emphasize the need for familiarity with the resuscitation techniques of Jude, Kouwenhoven and Knickerbocker[6] and for organization of cardiac arrest teams and procedures.

2. Arrhythmias. (a) Premature ventricular beats. Routine prophylactic use of quinidine or procainamide does not seem wise, but one or the other of these drugs should be promptly exhibited if frequent ventricular premature beats appear or become more frequent after infarction.

(b) Atrial fibrillation and flutter. When these arrhythmias complicate acute infarction, they may be transient. If they persist for longer than 2 hours or are accompanied by hypotension, dyspnea or chest pain, rapid digitalization with one of the short-acting preparations such as lanatoside C is necessary. If normal sinus rhythm does not supervene, conversion should be attempted with quinidine or procainamide by the oral or parenteral route, depending on the status of the patient. If these drugs are ineffective, or if time is a factor, direct current (DC) electroshock as developed by Lown and associates[7] usually is successful and, in experience to date, safe.

(c) Ventricular tachycardia. This ominous arrhythmia is always treated as an emergency with intravenous procainamide and, if unsuccessful, by DC countershock.

(d) Complete heart block with Stokes-Adams attacks is an uncommon complication and may be transient, with long-term survival possible. A 50 per cent mortality, however, usually has been experienced but modern methods should decrease this. Corticosteroids have appeared to be beneficial and a trial of long-acting isoproterenol[8] also is in order. If the condition persists, a small electronic pacemaker attached by a venous intracardiac catheter electrode inserted into the right ventricle may be life-saving and may be left in place for days or weeks. The use of a transistorized, implanted pacemaker may be necessary if complete heart block persists.

3. Shock. This may disappear with relief of pain. If systolic blood pressure persists below 90 mm., pressor agents are used. First choice is metaraminol. It is usually effective by intravenous drip and does not result in a slough if extravasation occurs. Its mechanism of action appears to involve release of norepinephine from tissue stores.[9] If ineffective, levarterenol is substituted. Angiotensin II is the most powerful pressor known, but its place in the treatment of cardiogenic shock is unsettled.

4. Acute pulmonary edema is treated conventionally with oxygen, morphine, digitalization, rotating tourniquets and, if necessary, removal of 350 to 400 ml. of blood by phlebotomy.

5. Ventricular aneurysm occurs in about 10 per cent of cases after myocardial infarction. However, it is rarely a cause of death.[10] Most individuals with this complication die of recurrent infarction or unrelated causes. If there are recurrent emboli despite adequate anticoagulation or intractable congestive failure, the aneurysm may be surgically excised and the defect repaired. The risk of surgery is from 11 per cent to 30 per cent.

C. Angina Pectoris

The individual with sudden appearance of or sudden increase in severity of, angina pectoris should be placed at bed-chair rest for at least 2 weeks and the electrocardiogram, serum enzymes and other parameters followed closely. The risk of sudden death or myocardial infarction is great in this situation. Anticoagulation probably is beneficial. Chronic stable angina pectoris has a better prognosis than formerly thought and is managed with sublingual nitroglycerin, correction of any extra-coronary factors (anemia, et cetra), and adjustment of activity below the pain threshold. So-called long-acting coronary vasodilators may be used but are of questionable value. In the presence of severe intractable angina, thyroid suppression with I^{131} may be used but adds a second chronic disease process which may complicate management.

Surgery for CHD remains experimental.

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The Basic Issue

On January 20 the House Ways and Means Committee resumed its hearings on the King-Anderson bill—H. R. 3920, " a bill to provide under the social security program for payment for hospital and related services to aged beneficiaries." Five days before the resumption of the hearings, President Johnson stated at a Washington, D. C., meeting of 47 national leaders of senior-citizen groups that the Administration has just begun to fight for its Medicare plan and vowed it is "going to be the law of the land."

Now that the political cauldron has been reheated over the Medicare issue, the usual ebullient charges and counter charges are again making headlines, and as anticipated, the steam generated beclouds rather than clarifies the basic issue: Should the federal Government, through the Social Security mechanism, provide certain hospital services for a large segment of the population (approximately 18,000,000 persons sixty-five or over), irrespective of need?

The original intent of the Social Security Act was to provide *cash* benefits to those who suffered a loss of job income due to old age, premature death of the family breadwinner and—more recently—total and permanent disability.

Laurence J. Ackerman, formerly Dean of the School of Business Administration, University of Connecticut, has made the following points:

> Benefits would bear some relationship—although not a directly proportional one—to the earnings on which an employer and his employee, or a self-employed person, were compelled to pay social security taxes. Benefits were to be paid in cash. This latter foundation stone rested on the ideas of simplicity of operation, and the more important concept, that it was the privilege of each American to decide how best to spend his income. This latter belief rests on the deeper premise of preservation of individual human dignity and self-respect.
>
> The Medicare bill would abandon these principles. Health care services would be provided to those who might still be working full-time. Thus, Social Security protection would be given to those who have experienced no loss of job income. Further, since the health care protection would be the same for all at age 65, the fundamental principle in Social Security of wage relationship to benefits would be abandoned. Finally, the furnishing of benefits as a service rather than through cash will deny to the individual the freedom of choice presumably inherent in our society.

Abandonment of these principles may not in itself augur the end of "the American Way of Life" (President Johnson called Medicare "The prudent American way"); it does, however, demonstrate a fundamental change in social philosophy by making individuals, as Mr. Ackerman states, "dependent upon government rather than making them independent."

Although the federal Government is already providing medical services to various segments of the population, no existing program approaches that envisioned in H. R. 3920. If adopted by Congress, H. R. 3920 will establish a precedent that is irreversible, and will effect the enactment of a vast, federally administered health program destined for expansion.—The New England Journal of Medicine.

Special Article

The History of E.E.N.T. Practice in West Virginia

William F. Beckner, M. D.

Organized medicine in the State of West Virginia began with the birth of the West Virginia State Medical Association in Fairmont on April 10, 1867, less than four years after West Virginia was admitted as the 35th State of the Union (June 20, 1863). Twenty-one physicians were present at this historic event and during the next decade most of the physicians of West Virginia practiced their profession primarily as general practitioners, although some showed special interest in diseases of the Eye, Ear, Nose and Throat. Unfortunately, as there are few accurate records from those early years much of the following data is incomplete and many actual facts have died in the dim past with the pioneers of Eye, Ear, Nose and Throat as a specialty in the practice of medicine.

Dr. John L. Dickey opened his office in Wheeling in 1883, first as a general practitioner and then as a specialist in diseases of the eye. He was president of the West Virginia State Medical Association in 1899, and practiced in Wheeling for 46 years.

As far as I can determine, however, the first physician to start his practice in the specialty of E. E. N. T. in the State of West Virginia was Dr. Gustavus Aschman, who opened his office in Wheeling in 1890. He was a graduate of the University of Zurich and had spent two and a half additional years studying diseases of the eye, ear, nose and throat in Vienna, Berlin and London. He also served as a president of the West Virginia State Medical Association in 1902, and he practiced E. E. N. T. in Wheeling until his death in 1921.

During the early 1890's other physicians began opening their offices in the State of West Virginia, with practices limited to diseases of the eye, ear, nose and throat. These included Dr. Harry Osterling in Wheeling, Dr. Charles B. Wylie in Morgantown, and Doctor Cherry in Huntington. The latter practiced only about four years when he developed tuberculosis.

Submitted to the Publication Committee, October 1, 1963.

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In 1892, Dr. V. T. Churchman located in Charleston and was that city's pioneer E. E. N. T. specialist. He also served as president of the West Virginia State Medical Association in 1909. His medical training was at the University of Virginia and Jefferson Medical College in Philadelphia, with two years specialty training at Jefferson.

Dr. John M. Fawcett settled in Wheeling in 1895, having graduated from Pulte Medical College in Cincinnati, with graduate training in E. E. N. T. at the New York Postgraduate School.

In 1897, Dr. T. W. Moore took over the office of Doctor Cherry in Huntington where he practiced E. E. N. T. until his retirement in 1950. He took graduate training at the Ophthalmic and Aural Institute in New York City, later several graduate courses in the clinics in Vienna. He also was president of the West Virginia State Medical Association in 1910, and served as president of the Southern Medical Association in 1929.

After the turn of the century numerous physicians practicing E. E. N. T. were noted in many cities throughout the State. Dr. H. R. Johnson located in Fairmont in 1903, after having practiced for a short time at Ronceverte. He received his training at the Manhattan Eye, Ear, and Throat Hospital, and was president of the West Virginia State Medical Association in 1920. Other physicians opening their offices for specialty practice between 1900 and 1910 included Dr. J. C. Geiger and Dr. C. M. Hawes in Huntington; Dr. E. A. Hildreth, Jr., Dr. M. B. Kelley, Dr. A. L. Coyle, and Dr. E. W. Woodruff in Wheeling.

Since 1910 many E. E. N. T. specialists have located throughout the State and their names are

too numerous to mention individually. It is of interest, however, to note that the first formal organization as a group was the development of the Eye, Ear, Nose and Throat Section of the West Virginia State Medical Association. This took place at the 57th Annual Meeting of the West Virginia State Medical Association in Wheeling in 1924.

Early in 1924, Dr. Ivan Fawcett contacted all the doctors practicing E. E. N. T. in the State, suggesting that they organize as a group and hold meetings in conjunction with those of the State Medical Association. He invited Doctors Clerf and Tucker of the Jackson Clinic in Philadelphia to present the program at the first meeting of the group in 1924. One of their papers was the Dowling or Argyrol pack of the nostrils for colds and nasal sinus infection. For about a year they had experimented with this treatment on members of the Philadelphia Police Department.

We elected Doctor Fawcett as our first president. It is interesting to note that all of the older E. E. N. T. doctors in the State boycotted this meeting, saying the general meeting was the only place they met the general men and they could cultivate their acquaintance with an ulterior motive of having them refer their patients to the E. E. N. T. men.

They considered Doctor Fawcett a young upstart cutting into their routine of running things. I know the ophthalmologists and otolaryngologists are a better prepared group today to practice our profession as a result of the clear, unselfish thinking and courage of Doctor Fawcett. We owe him a debt of gratitude.

The E. E. N. T. Section continued to hold its annual meetings conjointly with the State Medical Association until 1947. At that time, the House of Delegates of the State Medical Association approved the establishment of the West Virginia Academy of Ophthalmology and Otolaryngology to take the place of the E. E. N. T. Section. It also was decided at that time that there would be two meetings of the organization annually—one to be known as the "annual meeting" and the other as the "regular meeting." Annual meetings are held during the annual meeting of the State Medical Association, and the regular four-day meetings are held at another time during the year.

The Crashing Story of Glass Houses

The American people are ingenious beyond belief in discovering weird, esoteric ways of clobbering themselves. About 10,000 are injured each year while playing golf. Tongues are speared on the tines of forks at meal time. Injuries to milady's eyes and lungs from hair sprays have been reported.

But the glass door syndrome seems to be getting uncomfortably frequent, and ridiculous as it may sound, it's no laughing matter. The American Medical Association reports that an estimated 40,000 persons tried to walk through glass doors, window walls, and picture windows last year. About 6,000 were hospitalized, and some died from severe cuts and blood loss.

The U. S. Public Health Service made studies of glass door injuries in Dade County (Miami), Florida, two years ago, and these investigations have been continued in other localities. Findings show that two-thirds of the injuries occur to males, while children between 5 and 14 years account for a third. About three-fourths of the mishaps are in the home, and in three out of four instances, the shattering experience comes when the victim is trying to pass from the inside to the outside.

So serious and frequent has this hazard become that some few communities have amended residential building codes to require safety glass in doors and panels. AMA observes this as a good preventive measure, saying that "safety glass can raise a bump, but it won't shatter and cut." The report suggests decorative taping to warn that glass isn't just daylight. Except in rare instances of a stumbling fall, glass door injuries are almost entirely preventable. Let's look—and think—before we crash.—R. B. K., in Journal of the Mississippi State Medical Association.

The President's Page

The Role of Medicine in a Changing Society

THE past few decades have seen the most rapid and revolutionary changes made in the branches of the scientific world than in any era on record. This research and development has had a tremendous impact upon the intellectual, industrial and productive life of our country. It has, in fact, created problems in human relations, education and democratic government. An adequate solution of these problems will require wisdom, unselfish leadership and much faith in man's integrity.

The result of changes and discoveries has been to raise the question of the ability of men to properly use this great power of knowledge for the betterment of the human race. In short, we are faced with a two-fold problem. Externally, there are economics, physical inventions of science-technology, manufacturing and exploration of the fabric of life itself. Parallel with this, there are the internal factors of man's understanding and ordering of his own life, his own basic character.

Medical science has advanced as rapidly as the other scientific disciplines during this period of time. Simultaneously, there is the advance in the responsibility of the individual physician to thoroughly utilize this vast fund of knowledge in the prevention, diagnosis and treatment of disease processes.

The educational process of the modern physician, as a part of the ultimate goal of excellence, has increased in complexity and has tended toward increased specialization. Medical education begins with the early schooling of the individual and continues through college, medical school and internship. It has become imperative that postgraduate medical education be continuous throughout the years of practice of each physician, and only the latter can assure the high standard desired and demanded by both the profession and the public.

The ultimate beneficiaries of medical education are the recipients of medical care—the individual patients. Therefore, it is essential that the close relationship between doctor and patient be maintained and encouraged to secure the maximum benefit of both. There is no place in modern society for assembly-line medical practice, or the interjection of any foreign influence between doctor and patient. Medical practice is still both an art and a science, and its success is assured as long as mutual understanding exists between the public and the profession.

We live in a society still essentially free, one that gives to each individual the right of choice, which includes that of his physician. Throughout the history of mankind such a society has not been the general rule, but the exception. Thus far it has been proven successful in this Nation.

In conclusion, I quote the words of Thomas Paine who said: "Those who expect to reap the blessings of freedom must, like men, undergo the fatigue of supporting it."

Charles L. Goodhand

Charles L. Goodhand, M. D., President

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EDITORIALS

ACCLIMATIZATION TO ALTITUDE

There are times, both in peace and in war, that personnel, especially those in the armed forces, will have to live and perhaps fight at high altitudes. Presumably the average unacclimatized person who has normal health can get along quite well at altitudes up to 5,000 or even 6,000 feet. It will be recalled that the city of Denver, Colorado, lies at the first named altitude and the city of Colorado Springs, also in Colorado, at the latter. At altitudes well over 6,000 feet, however, the average unacclimatized person may become breathless upon moderate muscular exertion.

There is convincing evidence that people who live in the lowlands, even though they may be physically fit, may suffer varying degrees of incapacitation on rapid transport to high elevations, and the higher the altitudes the more severe the incapacitation. It is highly important, of course, that if men are called upon to fight at high altitudes, that they be able to give a good account of themselves. They can do so only if they are reasonably well acclimatized.

There is good evidence that physical training at altitudes from 6,000 to 8,000 feet will serve usefully for operations at 10,000 to 12,000 feet, and training at the latter altitude for operations at 15,000 feet. It should be emphasized that the last named altitude is capable of producing a severe degree of hypoxia. It is appropriate to mention that Pike's Peak rises to 14,100 feet above sea level.

The cogent question arises what practical measures can be used to acclimatize a large number of soldiers, for instance, an entire battalion. It has been pointed out by Luft[1] that a sojourn from ten to fourteen days at an altitude from 8,000 to 10,000 feet will aid significantly in increasing hypoxic tolerance. Beneficial effects so gained will last about three weeks. Luft showed further that if subjects expose themselves to the above mentioned altitudes, for at least an hour each day, acclimatization would persist.

It is admitted that it would be difficult for large groups of people to do this. Unfortunately, proper equipment to enable them to maintain acclimatization may not be available. This, however can be adequately arranged for an individual.

It may be that for one reason or another a person wishes to retain his previously acquired acclimatization. One of the most practical and least expensive methods is for the subject to breathe out of a Douglas bag. The bag may be filled with an oxygen-nitrogen mixture so that any altitude may be simulated. It would be possible, and presumably less expensive, if the Douglas bag were filled with ambient air which had been diluted with nitrogen to the desired

proportion. It would not be a hardship for a subject to breathe out of a Douglas bag for an hour each day. In fact, he could read or write when he was so doing.

In summary, acclimatization to altitude is of more than academic interest. The subject is of especial importance to those in the armed forces who are required to fight at high altitudes; indeed, whether a soldier is reasonably well acclimatized or not might make the difference between survival and death.

1. Luft, U. C., *Aerospace Medicine*, (Baltimore: Williams and Wilkins Co., 1961), p. 138.

NEEDED: RURAL HEALTH COUNCIL

The West Virginia State Medical Association has a continuing interest in providing competent medical practitioners in rural West Virginia. There have been several articles on this subject in *The Journal* in recent years. The following editorial in the February issue of the *Virginia Medical Monthly,* written by Edgar J. Fisher, Jr., Director of the Virginia Council on Health and Medical Care, indicates that a similar situation exists on the Eastern side of Appalachia.

"The need for family physicians in rural Virginia has never been as great as it is today. The opportunities for physicians to practice high quality medicine in modern facilities where they are needed, wanted and will be supported, in any part of Virginia, are almost unlimited. Yet there appears to be less interest in general practice today among medical students and interns than previously.

"The prospect of not being able to help meet the physician needs of rural Virginia is one of the utmost concern to the Virginia Council on Health and Medical Care. . . .

"Since 1950 the Virginia Council on Health and Medical Care has administered a Physician Referral Service with the cooperation of The Medical Society of Virginia, the Medical College of Virginia, the University of Virginia, the State Department of Health, the State Board of Medical Examiners, and the American Medical Association. The service has grown steadily over the years, and has been cited by many physicians who have used it as the most active and effective service among the many state services they have used. The Virginia Council serves as a clearinghouse for communities needing physicians and doctors looking for suitable locations to practice. . . .

"Helping people in rural areas to help themselves attract good medical care is essential to the security of those areas, to their healthy 'climate' or potential for attracting new industry, to their local economy and to all phases of community life. A physician in a rural area is the keystone upon which most health activity depends for its stability and strength."

This editorial indicates increasing difficulty in procuring general practitioners and specialists to fill practice opportunities in Virginia. In West Virginia our problem is not less difficult. We have had communities and organizations dedicated to a solution of the problem but our results are still unsatisfactory. We need a new approach and more cohesion through a joint effort of interested agencies.

A planning committee or rural health council should include representation from our Association, the AMA, State Department of Health, Medical Licensing Board, WVU School of Medicine, the University Extension Service, the Farm Bureau and other active rural agencies. Such a council could determine precisely the extent of our problem and how we can meet our rural demand. Like all such schemes, cooperation is essential and communities will have to provide substantial assistance toward their own medical relief.

It has been shown that those communities that have made outstanding efforts in their own behalf usually attract a physician to their midst.

County medical societies are urged to provide a courtesy membership for all medical students from their locale. If a lively interest is maintained in the student through graduation and residency he is likely to establish a practice in his home community. Excellent internships and residencies in West Virginia go to out-of-state physicians and foreign graduates. Many are unfilled. A special rural council might maintain a closer and warmer relationship between faculty, students and hospitals. Such a dedicated group might keep at least a majority of our recent West Virginia graduates at home.

Medical students succumb readily to the lure of specialty practice. They should also receive instruction in the rudiments and principles of general medicine by general practitioners who are not courtesy lecturers but regular staff appointees.

There are many unexplored avenues to improve rural health facilities. In the sparsely settled sections of our State immediate medical service will never be available. But better means can be provided to get the patient to the office or community hospital where medical service will be more effective than a house call.

GENERAL NEWS

Drs. Nelson and Krantz To Speak At 97th Annual Meeting

A prominent pediatrician and an authority in the field of pharmacology will be among the guest speakers at the 97th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 20-22.

Dr. William E. Gilmore of Parkersburg, Chairman of the Program Committee, announced that Drs. Waldo E. Nelson of Philadelphia and John C. Krantz, Jr., of Baltimore, have accepted invitations to present papers during the three-day meeting.

Waldo E. Nelson, M. D.

John C. Krantz, Jr., Ph.D.

Doctor Nelson, who is Professor and Head of the Department of Pediatrics at the Temple University School of Medicine, will appear as a speaker at the second general scientific session on Friday morning, August 21.

Doctor Nelson was born in McClure, Ohio, and was graduated from Wittenberg College. He received his M. D. degree in 1926 from the University of Cincinnati College of Medicine and interned at Cincinnati General Hospital, 1926-27. He served residencies there and at the Children's Hospital, 1927-29.

He joined the faculty of the University of Cincinnati College of Medicine in 1929 and was Associate Professor of Pediatrics when he resigned in 1940 to accept appointment as Professor and Chairman of the Department of Pediatrics at Temple University School of Medicine. He also has served as Medical Director of the St. Christopher's Hospital for Children in Philadelphia since 1948.

He has served as Editor of the *Journal of Pediatrics* since 1959 and he is the author of *Textbook of Pediatrics* which is now in its seventh edition.

He was awarded an honorary degree by Wittenberg College in 1956.

John C. Krantz, Jr., Ph. D.

Dr. John C. Krantz, Jr., who is Professor and Head of the Department of Pharmacology at the University of Maryland School of Medicine, also will appear as a speaker at the second general session on Friday morning, August 21. His subject will be "The Response of Cells to Drugs."

Doctor Krantz was graduated from the University of Maryland and also received M. S. and Ph. D. degrees from that University. He served as Professor of Pharmacy at the University of Maryland School of Pharmacy and as Professor of Chemistry at the University of Maryland School of Dentistry.

He served as Director of Pharmacology Research for Sharp and Dohme, 1927-30, and as Chief of the Bureau of Chemistry of the Maryland State Department of Health, 1930-35. He has served as Professor and Head of the Department of Pharmacology at the University of Maryland School of Medicine since 1935.

He is vice president, council member and representative to the National Research Council—American Society of Pharmacology and Experimental Therapeutics. He is secretary of the U. S. Pharmacopeia, and is serving as Chairman of the Advisory Council to the Maryland State Department of Health.

He is the author of three books and more than three hundred scientific papers. He is an associate member of the Medical and Chirurgical Faculty of Maryland and the American Medical Association.

Scientific Program Nearly Completed

Doctor Gilmore announced that arrangements have nearly been completed for the general scientific program which will be presented during the three-day meeting. The other members of the Program Committee are Drs. Robert D. Crooks of Parkersburg, George F. Evans of Clarksburg, Richard E. Flood of Weirton, Seigle W. Parks of Fairmont and Clark K. Sleeth of Morgantown.

It was announced previously that one of the honor guests at the meeting will be Dr. Perry E. Gresham, President of Bethany College. He will speak at the first general scientific session on Thursday morning, August 20.

Additional information concerning the convention at The Greenbrier will appear in future issues of *The Journal*. The complete program will appear in the issue for August.

Large W. Va. Delegation Attends Conference on Rural Health

A large delegation of West Virginians attended the American Medical Association's 17th National Conference on Rural Health which was held at the Columbus Plaza in Columbus, Ohio, March 6-7.

Dr. Paul A. Miller, President of West Virginia University, delivered the keynote address at the opening session of the two-day meeting on Friday morning.

Dr. Earl L. Fisher of Gassaway, Chairman of the West Virginia State Medical Association's Committee on Rural Health, led off the second portion of the afternoon session on Friday.

Other West Virginians who attended included:

State Director of Health Dr. N. H. Dyer and Mrs. Dyer.

Dr. N. Allen Dyer, a member of the State Department of Health Staff, and Mrs. Dyer.

Mrs. Pat A. Tuckwiller of Charleston, President of the Woman's Auxiliary to the West Virginia State Medical Association.

Mrs. L. Dale Simmons of Clarksburg, Chairman of the Auxiliary's Legislative Committee.

Mrs. Lynwood D. Zinn of Clarksburg, Chairman of the Auxiliary's Rural Health Committee.

Mrs. J. C. Huffman of Buckhannon, National Regional Chairman of the Rural Health Committee of the Woman's Auxiliary to the American Medical Association.

Miss Elizabeth Ann Roberts of Morgantown, a member of the Advisory Committee to the State Medical Association's Committee on Rural Health.

Changing Rural America

Doctor Miller, a West Virginia University graduate who once served as a county agent, received generous applause following his kenote address on "Changing Rural America—Guidelines and New Meanings."

Doctor Fisher, who has practiced in Central West Virginia for 27 years, discussed "The Importance of State Rural Health Conferences" before a well-attended Friday afternoon session.

Dr. Paul A. Miller, left, President of West Virginia University, and Dr. Earl L. Fisher of Gassaway, were among the speakers at the National Conference on Rural Health. Doctor Miller delivered the keynote address and Doctor Fisher discussed "The Importance of State Rural Health Conferences."

He described the annual Rural Health Conferences, which have been held in West Virginia since 1947, as "one of the most important and rewarding activities undertaken by the West Virginia State Medical Association."

"We leave these conferences with a sense of pride and a feeling that much has been accomplished—not only for the individuals in attendance, but also for those persons back home who will hear reports of the proceedings," he said.

Dr. Edward H. Rynearson, Senior Consultant at The Mayo Clinic, Rochester, Minnesota, opened the Friday afternoon session. His topic was "The Physician, the Clergy, the Patient."

State Director of Health Dr. N. H. Dyer, left, and his son, Dr. N. Allen Dyer, right, are shown with American Medical Association Field Representative Harry R. Hinton at the 17th National Conference on Rural Health which was held in Columbus, Ohio, March 6-7. On the right, Mrs. Lynwood D. Zinn, left, and Mrs. L. Dale Simmons, right, both of Clarksburg, are shown with Mrs. Calvin Warner of Cincinnati, President of the Woman's Auxiliary to the Ohio State Medical Association.

Auxiliary President Speaks

Mrs. C. Rodney Stoltz of Watertown, South Dakota, President of the Woman's Auxiliary to the American Medical Association, delivered an address on "Women's Role in Health Programs" at the Friday night banquet.

The main address on "Bread for the World" was presented by the Rev. Dr. Reginald H. Helfferich of Amston, Connecticut, general secretary for world service of the United Church Board of World Ministries.

The Four Dreams of Man

The closing session on Saturday morning was devoted to "Teenage Health Tune-Ups." Speakers included W. W. (Woody) Hayes, head football coach at Ohio State University, and Dr. W. Hugh Missildine, Associate Professor of Psychiatry at the Ohio State University College of Medicine.

A four-member panel of Ohio college and high school students discussed "Parent or Youth Responsibility." This was followed by a question and answer session with audience participation.

Dr. John H. Furbay of Forest Hills, New York, Director of TWA Air World Education, closed the conference with an inspiring address on "The Four Dreams of Man."

State Physicians Invited to Attend Meeting in Kentucky

The 14th Annual Interim Meeting of the Kentucky State Medical Association will be held at the Jenny Wiley State Park in Prestonsburg on April 23.

Dr. Ernest B. Howard, Assistant Executive Vice President of the American Medical Association, and Dr. Durward G. Hall, a member of Congress from Missouri, will be among the speakers at the one-day session.

Other speakers include Dr. Daniel F. Hanley of Brunswick, Maine; Dr. Nicholas Nyaradi of Peoria, Illinois, and Mr. Clarence N. Walker of Atlanta, Executive Staff Representative of the Coca-Cola Company, who will be the speaker at the luncheon session.

West Virginia physicians interested in attending the meeting should contact Mr. Joe P. Sanford, Executive Secretary of the Kentucky State Medical Association, 3532 Janet Avenue, Louisville, 40205.

W. A. Nichols New Executive Director Of State Cancer Society

William A. Nichols has been appointed executive director of the West Virginia Division of the West Virginia Cancer Society. The appointment was announced late in February by Dr. John C. Condry of Charleston, president of the organization.

Mr. Nichols, who succeeded John H. Yeatts, has been serving with the American Cancer Society's Pennsylvania Division for the past eight years.

Mrs. Pat A. Tuckwiller of Charleston and Mrs. J. C. Huffman of Buckhannon are shown with Mrs. C. C. Long of Ozark, Arkansas, right, at the National Conference on Rural Health, which was held in Columbus, Ohio. Mrs. Long is Rural Health Chairman of the Woman's Auxiliary to the American Medical Association.

WVU Medical Student Awarded AAMC Foreign Fellowship

Linda D. Lewis, a junior in the West Virginia University School of Medicine, has been awarded a Foreign Fellowship which will enable her to obtain supervised medical experience in a relatively underdeveloped area of the world.

Miss Lewis, whose home is in Beechbottom, Brooke County, will spend at least ten weeks at the Christian Hospital in Mungeli, India.

The program is sponsored by the Association of American Medical Colleges and the Fellowships are made possible by a grant from Smith, Kline & French Laboratories of Philadelphia. Twenty-nine junior and senior U.S. medical students were awarded Fellowships this year for study in countries of Southeast Asia, Africa, Central and South America and Oceania.

The primary objective of the Fellowships is to provide students an opportunity to benefit from unusual clinical experiences and familiarize themselves with medical, cultural and social problems different from their own. They will be stationed in mission hospitals and outpost medical facilities.

Annual Meeting in Baltimore, May 6-8

The 166th Annual Meeting of the Medical and Chirurgical Faculty of the State of Maryland will be held at the Alcazar in Baltimore, May 6-8.

Dr. Edward R. Annis, President of the American Medical Association, will be the speaker at the Presidential Dinner, and twelve prominent physicians and surgeons will present papers at the scientific sessions.

Physicians interested in attending the meeting should write Dr. J. B. Workman, Program Chairman, 1211 Cathedral Street, Baltimore 21201.

Report of Compensation Sub-Committee Of Medical Economics Committee

There has been, for many years, dissatisfaction with many of the rules and regulations of the Workmen's Compensation Commission in the State of West Virginia as they pertain to the medical care program. As a result of many meetings of the Compensation Sub-Committee of the Medical Economics Committee of the West Virginia State Medical Association, the following problems are listed:

A. Deficiency in Patient Care

(1) It is felt that patients have insufficient funds earmarked by the Workmen's Compensation Commission for their treatment and rehabilitation, particularly in the severely injured, long-term cases. It is not infrequent that funds are depleted before the patients have reached maximum improvement. This frequently leaves hospitals and physicians in a position of rendering continued medical care without financial reimbursement. This also frequently results in a denial of the receipt of services from laboratories, x-ray and physical therapy facilities.

(2) It is believed that with the increase in the cost of living, the weekly stipend for the patient is much too low. It is barely enough for existence, much less at times than is necessary to insure proper nutrition.

(3) At the present time the amount of money paid to a patient as temporary disability is subtracted from his total award upon the granting of a partial disability rating. We definitely feel that this law is improper. It imposes a particular hardship on a severely injured patient who has been hospitalized and disabled for many months and who may or may not be able to return to gainful employment. As a result, it is not infrequent that the award has been used up entirely by the amount paid out for temporary disability while he is receiving treatment. It is recognized by our group that many patients are not severely injured and attempts are made to "ride" compensation funds to the extreme. It is understood that some action would have to be taken to limit the abuse of such funds by freeloaders.

(4) In the past there has been considerable delay in obtaining authorization for treatment of a patient whether it be surgery, physical therapy, braces or additional work-up. This frequently has worked to the detriment of the patient and ultimately to the disadvantage of the Compensation Commission as far as its total monetary outlay is concerned in the care of these patients. The longer the delay in getting treatment for the patient, the less likelihood there is of getting a good result and returning the patient to gainful employment. In the past it has been felt that surgical procedures have not been authorized when they would improve the patient's physical status, although not perhaps allow him to return to gainful employment. We feel the patient deserves to return to his best possible physical condition and we believe he has this right whether he is made available for the labor force or not.

B. Financial Loss to the Physician

The fee schedule of the Workmen's Compensation Commission is extremely low as compared with most other states. The extreme inadequacy of payment for services rendered, along with various disallowances has led to considerable dissatisfaction. There is no reason why, as a group, the medical profession should subsidize the Compensation Medical Care Program. The physician should receive reasonable compensation for services rendered. It is only due to the fact that we are dedicated and interested in taking care of the patient that we have continued so long in giving the best possible care even though at times we are upset by the various rulings and low remuneration.

These problems were presented to the Council of the West Virginia State Medical Association. Added to these problems was that of the inadequate disability regulations which prolong litigation, provide inadequate regulations for uniform disability recommendations and thereby predispose to excessive disability ratings in some cases and inadequate ratings in others, with the resulting implication of bias among physicians giving medical testimony. The following recommendations were made:

Recommendations

(1) Medical Director: The Committee strongly recommends that a full-time Medical Director be appointed at a realistic salary which will encourage a physician to stay on the job.

(2) Commissioner: We would strongly recommend that the Compensation Commissioner be appointed, again at a realistic salary, and on a continuing basis.

(3) We believe that the weekly stipend to the patient should be increased. Inadequate weekly stipends during temporary total disability can result in only two things. Either a patient, by virtue of the inadequate pay, is forced to return to work before medically sound or he develops an animosity toward the Commission and physician, remains on temporary total disability as long as possible and then goes to all ends to recover the financial loss which has resulted from his injuries.

(4) We would encourage an increase in the total treatment fund. We believe the patient is deserving of whatever treatment that can logically be expected to give him benefit and obtain for him the opportunity to return to the best possible physical condition, whether or not it be a return to his regular job.

(5) It is our opinion that, in those patients disabled beyond ability to return to work, they should receive disability awards without subtraction of the money already paid out on a temporary disability basis.

(6) We recommend the establishment of a medical committee or a review board for the purpose of reviewing problem cases and grievances brought by

both physicians and the Commission. We believe that when a patient is given a permanent partial disability rating his case should be closed without further access to reopening a claim unless there has been a proper presentation of medical facts which, in the opinion of the medical review board, justify an increase in the patient's disability rating. A limitation of 5 years should be established for the presentation of such evidence. It is further recommended that a detailed schedule of disability ratings for various physical defects be developed by the Commission, with the assistance of the medical profession, in order to minimize as much as possible the frequent wide variances of percentages recommended for the compensation case.

(7) We strongly recommend the formation of a Compensation Rehabilitation Center, with the staff specifically trained in physical rehabilitation, particularly in physical exercises to aid the injured patient to return to full active labor.

(8) Fee Schedule: At this time members of the Medical Economics Committee of the West Virginia State Medical Association are in the process of developing a fee schedule which will allow reasonable compensation for services rendered in this area.

These basic problems and recommendations were first presented to the Compensation Commissioner and then to Gov. W. W. Barron. We are now awaiting a joint conference with the Compensation Commissioner and the Governor for the purpose of discussing the implementation of these recommendations.

We extend a special vote of thanks to the entire membership of the Sub-Committee.

Respectfully submitted,

George R. Callender, Jr., M. D.,
Chairman, Medical Economics Committee

Henry M. Hills, Jr., M. D.
Chairman, Compensation Sub-Committee

18 Physicians Licensed by MLB To Practice in State

The Medical Licensing Board licensed 18 physicians, 11 by examination and 7 by reciprocity, at a meeting held at The Capitol in Charleston, January 20-22, 1964. The following physicians were licensed by direct examination:

Aguado, Enrique, Huntington
Andrew, John Hollis, Weston
Barton, William Raymond, Wheeling
Beruben, Miguel F., Madison
Capinpin, Alberto G., Charleston

Gardner, James Anderson, Beckley
Martinez-Tapia, Antonio C., Charleston
Papadimitriou, Basil Paul, Wellsburg
Payuyo, Sergio A., Logan
Schmid, William H., Point Mugu, Calif.
Young, Michael Ming Cheng, Weston

The following is a list of the physicians who were licensed by reciprocity:

Barnes, Asa, Beckley
Bernhardt, Donald Robert, Parkersburg
Burns, Wendell Mallory, Huntington
McRae, Henry Grady, Beckley
Shepard, Roberta Jane, Huntington
Vanstane, Virgil Rolla, Whitesville
Vosburg, Robert Louis, Morgantown

The next meeting of the Medical Licensing Board will be held at The Capitol in Charleston on April 27, 1964, for the purpose of licensing physicians by reciprocity for the practice of medicine in West Virginia.

Summer Meeting in Kingwood

The Annual Summer Meeting of the Preston County Medical Society will be held at the Preston Country Club near Kingwood on Thursday, June 25.

Dr. John F. Lehman of Kingwood is general chairman for the meeting and Dr. W. Parke Johnson, Jr., of Masontown, is chairman of the program committee.

Dr. Harry S. Weeks, Jr., of Wheeling, new chairman of the Joint Conference Committee, is shown with other members prior to a February meeting with State Welfare Commissioner W. Bernard Smith in Charleston. Seated, Dr. William W. Wells of Mullens, Doctor Weeks and Dr. Roy W. Eshenaur of Pt. Pleasant. Standing, Drs. Seigle W. Parks of Fairmont, Thomas P. Long of Man and George R. Callender, Jr., of Charleston, chairman of the Medical Economics Committee.

17th Annual Oph. and Otol. Meeting At The Greenbrier, April 15-18

The 17th Annual Meeting of the West Virginia Academy of Ophthalmology and Otolaryngology will be held at The Greenbrier in White Sulphur Springs, April 15-18.

Dr. James T. Spencer of Charleston, the President, will preside at the four-day meeting. He announced that six out-of-state physicians will present papers at the general scientific sessions.

Physicians throughout the State have been invited to attend the meeting. A registration fee of $35 will cover all scientific sessions and social functions. Additional information may be obtained by writing to the secretary, Dr. Worthy W. McKinney, Professional Park, Beckley.

16th Annual AAGP Scientific Assembly In Atlantic City, April 13-16

The 16th Annual Scientific Assembly of the American Academy of General Practice will be held at Convention Hall in Atlantic City, April 13-16. More than 4,000 family physicians are expected to attend the four-day meeting.

Seigle W. Parks, M. D.

Carl B. Hall, M. D.

Dr. Seigle W. Parks of Fairmont and Dr. Carl B. Hall of Charleston will represent the West Virginia Chapter, AAGP. Alternate delegates are Drs. Myer Bogarad of Weirton and Halvard Wanger of Shepherdstown.

Doctor Parks is vice president of the West Virginia State Medical Association and both he and Doctor Hall are members of the Association's Committee on Medical Economics.

The West Virginia delegates will attend the two-day annual meeting of the Academy's Policy-Making Congress of Delegates, which will be held at the Shelburne Hotel, April 11-12.

The scientific program will open on Monday afternoon, April 13, and the Assembly this year will feature as its theme "The Family in Medical Perspective." This stems from growing recognition that if the family doctor is to provide comprehensive health care for the whole family, he must be alert and trained to view his patients in the light of their environment.

This means that his care must transcend the basic medical sciences and mere diagnosis and therapy, and involve application of the behavioral sciences—anthropology, psychology and sociology. The patient is a family member and the changes in behavioral patterns within the close-knit family situation can have tremendous impact on health.

Thirty-one prominent physicians and surgeons will present papers at the scientific sessions in Convention Hall. In addition, more than 200 scientific and industrial exhibits will be on display under the same roof.

The President's reception and dance will be held on Wednesday evening, April 15. Academy officers and their wives will receive guests at this social highlight of the meeting.

Preceding the reception, Dr. Julius Michaelson of Foley, Alabama, the president elect, will receive the gavel from Dr. Albert E. Ritt of St. Paul, Minnesota, the retiring president.

Auxiliary Meeting in Charleston

The annual Spring Meeting of the Executive Board of the Woman's Auxiliary to the West Virginia State Medical Association will be held at the Daniel Boone Hotel in Charleston, April 28-29.

Mrs. Pat A. Tuckwiller of Charleston, the President, will call the meeting to order at three o'clock on Tuesday afternoon, April 28. Dr. and Mrs. A. C. Chandler of Charleston will be the speakers at a dinner meeting that evening and their subject will be "International Health."

A workshop for county presidents and presidents elect will be conducted during the two-day meeting.

Medical Technologists Meeting In Parkersburg, May 1-2

Dr. David B. Thornburgh of Parkersburg will be among the guest speakers at the 16th Annual Meeting of The West Virginia State Society of Medical Technologists which will be held at the Holiday Inn in Parkersburg, May 1-2.

Doctor Thornburgh, who is pathologist at St. Joseph's Hospital in Parkersburg, will present a paper on "Importance of Cord Blood Bilirubin Determination."

Other speakers for the two-day meeting will be Dr. Coye C. Mason, Commissioner of Continuing Education for the American Society of Clinical Pathologists; Betholene F. Love, Associate Director of the Division of Medical Technology at the West Virginia University Medical Center; Robert L. Cutler, Regional Manager of Ames Company Inc.; Richard Yontz, Technical Representative for Dade Reagents Inc.; and Steven J. Koziel, Manager of Technical Education for Warner-Chilcott Laboratories.

Physicians and other interested persons have been invited to attend the meeting. Further information may be obtained by writing Lyle S. Dayhoff, M.T. (ASCP), Camden-Clark Hospital, Parkersburg.

Annual Meeting, W. Va. Chap., AAGP, In Charleston, May 15-17

More than two-hundred physicians are expected to attend the 12th Annual Scientific Assembly of the West Virginia Chapter of the American Academy of General Practice which will be held at the Charleston Civic Center, May 15-17.

Dr. Peter A. Haley of Charleston, general chairman of the Convention, announced that thirteen prominent physicians and surgeons already have accepted invitations to appear as guest speakers on the scientific program. General scientific sessions will be held mornings and afternoons on Saturday and Sunday in addition to an afternoon session on Friday, May 15.

Dr. Joseph A. Smith of Dunbar is president of the West Virginia Chapter; Doctor Haley, president elect; Dr. Jack Leckie of Huntington, vice president; Dr. L. Dale Simmons of Clarksburg, secretary; and Dr. Martha J. Coyner of Harrisville, treasurer.

Cooperative Programs Urged to Deal With Quackery in State

Increased concern over quackery in the United States has brought about recent federal legislation which will increase the enforcement power of the Federal Drug Administration, enabling it to intensify its efforts in this field.

State Director of Health Dr. N. H. Dyer, writing in his weekly State of the State's Health, said that "West Virginians can ill afford an estimated $8 to $10 million yearly to line the pockets of quacks." He urged federal, state and local cooperative efforts to destroy the $1 billion annual business of the charlatan who foists a myriad of useless cures, food fads and mechanical devices on the American public.

He noted that the fight against quackery has been waged in this country since 1847 and was the major reason for the establishment of the American Medical Association.

A recent publication of the U. S. Department of Health, Education and Welfare listed 36 categories of fraudulent products in the health field, ranging from air purifiers and alcoholism treatments through cancer cures. This pamphlet should be in the literature rack of all health departments, hospitals, clinics, offices of physicians and dentists, and on the counters of pharmacies throughout the state.

To effectively deal with quackery, local health departments in the State must develop their own built-in program against quackery through:

Cooperative programs with physicians, dentists, nurses, hospitals and clinics aimed at utilizing each patient contact for education.

Exposure of major frauds by means of mass media.

Distribution of literature, films and displays in connection with programs for community groups.

Setting up health education centers in pharmacies. At present, a pilot program based on this concept is now under way in one section of the state.

Improved instruction on quackery in schools.

Special education directed toward the aged.

Budget Slash Will Curtail Services

A reduction of $101,000 from the current federal allocation for the State, recommended in the President's budget request for the fiscal year beginning July 1, was discussed in another issue of the publication.

If the proposed budget stands, many of the State's basic public health services will be eliminated and others seriously curtailed. No federal funds will be available under formula grants for tuberculosis control. Matching funds for general health will be reduced by 29 per cent and by 11.1 per cent for chronic illness. During the current year, the department received $357,700 in these categories and the proposed budget calls for a total of $256,700, a cut of 28.2 per cent.

Some of the effects that the proposed cut will have on public health services in the State are as follows:

Discontinuation of services from two mobile X-ray units used throughout the State for case-finding in tuberculosis.

A meeting of the Special Committee named to study the Scholarship Program of the West Virginia State Medical Association was held in Charleston on February 23. Those attending were Drs. Maynard P. Pride of Morgantown, Pat A Tuckwiller of Charleston, E. Lyle Gage of Bluefield, chairman, and Albert C. Esposito of Huntington, president elect of the State Medical Association.

Elimination of the position for part-time physician-director in tuberculosis control.

Reductions in all staff for tuberculosis control.

Drastic curtailment in programs for the chronically ill and aged.

Elimination of five professional staff members from a project designed to improve care in nursing homes.

Cutbacks in assistance to several counties attempting to extend bedside nursing services.

Additional reduction of staff, at least 15 positions, in half of the state-level bureaus and divisions with responsibilities for direct services to the public and for direct, consultative and supervisory services to county health departments.

Coming at this time, when the state is experiencing extreme economic difficulties and when tuberculosis, chronic disease and many other health problems are on the rise, the proposed reduction will strike a heavy blow at vitally needed health projects in all sections of the State.

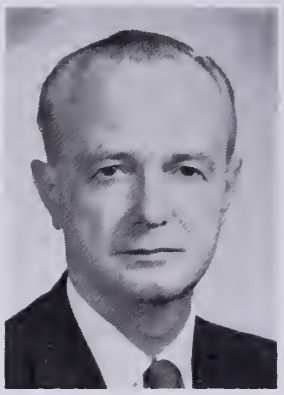
Medical Meetings, 1964

The following is a partial list of national, state and district medical meetings scheduled for 1964:

Apr. 6-10—ACP, Atlantic City.
Apr. 13-16—AAGP, Atlantic City.
Apr. 15-18—W. Va. Acad. Oph. and Otol., White Sulphur Springs.
Apr. 16-18—W. Va. Chapter, ACS, The Greenbrier, White Sulphur Springs.
Apr. 26-May 1—Ohio State Medical Assn., Columbus.
May 1-2—W. Va. Soc. Med. Technologists, Parkersburg.
May 6-8—Maryland Annual Meeting, Baltimore.
May 15-17—W. Va. Chapter, AAGP, Charleston.
June 21-25—AMA Annual Meeting, San Francisco.
June 25—Preston Co. Summer Session, Kingwood.
Aug. 20-22—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 4—W. Va. Heart Assn., Huntington.
Oct. 1—Rural Health Conf., Jackson's Mill.
Oct. 23-25—Potomac-Shenandoah Valley PG Institute, Martinsburg.
Oct. 23-25—American Heart Assn., Atlantic City.
Nov. 16-19—Southern Medical, Memphis, Tenn.
Nov. 29-Dec. 2—AMA Clinical Meeting, Miami Beach.

Three Out-of-State Speakers on ACS Program at The Greenbrier

Dr. Jack C. Morgan of Fairmont, President of the West Virginia Chapter, American College of Surgeons, will preside at the Annual Meeting of the Chapter which will be held at The Greenbrier in White Sulphur Springs, April 16-18.



George H. Yeager, M. D.

Three out-of-state physicians will present papers during the three-day meeting. They are Dr. Robert W. Buxton, Professor of Surgery at the University of Maryland School of Medicine; Dr. George H. Yeager, Clinical Professor of Surgery at the University of Maryland School of Medicine; and Dr. Kenneth W. Warren, a member of the surgical staff at the Lahey Clinic in Boston.

Dr. Hu C. Myers of Philippi, vice president and program chairman, said the mornings would be devoted to scientific sessions with the afternoons free. The program will be devoted largely to "Upper Abdominal Surgical Conditions."

The out-of-state speakers and their subjects are as follows:

George H. Yeager, M. D., Clinical Professor of Surgery, University of Maryland School of Medicine, "Hiatus Hernia," and "Abdominal Aneurysms."

Kenneth W. Warren, M. D., Lahey Clinic, Boston, "Chronic Pancreatitis," and "Obstructive Lesions of the Common Duct."

Robert W. Buxton, M. D., Professor of Surgery, University of Maryland School of Medicine (two lectures).

The West Virginia speakers and their subjects include:

F. Lloyd Blair, M. D., Parkersburg, "Aneurysm of the Pancreaticoduodenal Artery."

H. C. Wasson, Jr., M. D., Huntington, "Islet Cell Adenoma With Presentation of a Case."

Jack C. Morgan, M. D., Fairmont, "Hemoptysis of Obscure Origin."

Victor S. Skaff, M. D., Charleston, "Upper Gastrointestinal Bleeding."

The two winners of the Chapter's annual contest for residents in West Virginia hospitals also will present their papers during the meeting.

A cordial invitation to attend the meeting has been extended by the West Virginia Chapter to all practicing physicians in the State. There is no registration fee. Additional information may be obtained by writing the Secretary, Dr. E. F. Heiskell, Jr., Citizens Building, Morgantown.

The attempt to combine wisdom and power has only rarely been successful and then only for a short while.—Albert Einstein.

Mrs. W. W. Barron, wife of West Virginia's Governor, receives an explanation of the use of a fluoroscope in the diagnosis of heart problems from Dr. Russell V. Lucas, Jr., during a recent visit to the West Virginia University Medical Center. Mrs. Barron, honorary State Chairman of Heart Sunday, was conducted on a special tour of the Medical Center to view the programs of research, diagnosis and treatment of heart disease.

Dr. Thomas W. Nale Named Director Of Cabell Health Department

Dr. Thomas W. Nale of Huntington has assumed his duties as Director of the Cabell-Huntington Health Department. Doctor Nale succeeds Dr. R. D. Kimbrough who resigned in December. Doctor Kimbrough had replaced Dr. Bruce H. Pollock who resigned last summer because of ill health.

Doctor Nale, a native of McKeesport, Pennsylvania, retired recently as Medical Director of the Union Carbide Corporation. He attended the two-year WVU School of Medicine and received his M. D. degree in 1924 from Jefferson Medical College. He interned at Allegheny Hospital in Pittsburgh and served a residency at the Elizabeth Steel McGee Hospital in the same city. He is a Diplomate of the American Board of Preventive Medicine.

He served as Assistant Director of the Maternal and Child Hygiene Division of the West Virginia State Department of Health, 1937-38, at which time he was named Director. He joined the Medical Department of Carbide in 1941 and remained in South Charleston until 1946 when he was transferred to New York.

Doctor Scherr on Allergy Program

Dr. Merle S. Scherr of Charleston presented a paper at a Postgraduate Instructional Course which was sponsored by the American College of Allergists in Miami Beach on March 2. His subject was "Rehabilitation of the Allergic Child."

Doctor Scherr also participated in a panel discussion on rehabilitation in connection with the 20th Annual Congress of the College later that same week.

The West Virginia Medical Journal

May, 1964 Vol. 60, No. 5

Brain Abscess in Cyanotic Heart Disease

W. Scott Bowie, A. B., E. Lyle Gage, Jr., A. B., E. Lyle Gage, M. D., And Russell V. Lucas, Jr., M. D.

Certain diseases once considered only curious or rare at the autopsy table are curable today. Advances in treatment and prevention of infection, in diagnosis and surgical treatment of neurological disease and in the means of diagnosis and surgical correction of congenital heart disease, now provide for prevention or cure in the case of the patient with the combination of congenital heart disease and brain abscess.

Brain abscess long has been recognized as a complication of certain forms of congenital heart disease. Farre[1], in 1814, reported autopsy findings in the case of a patient with congenital heart defect and brain abscess. Other scattered cases subsequently were reported but were considered as no more than chance autopsy observations. The first recorded pre-mortem diagnosis of this entity appeared in 1932[2]. Smolik and associates[3], in 1946, reported successful results in the treatment of a case. Since that time many instances of successful treatment of brain abscess complicating congenital heart disease have been recorded.

The incidence of brain abscess in the presence of congenital heart disease is higher than is generally recognized. Moronde[4] reported 14 instances of brain abscess in a series of 209 cases of congenital heart defect, each of which had the potential for shunting venous blood directly into the systemic arterial system. Hanna[5], in post-mortem studies, found 6 instances of brain abscess in 160 cases of cyanotic congenital heart disease; Robbins[6], in a series of 53 cases of the latter, found brain abscess in 3. Thus, the patient dies of brain abscess in approximately 5 per cent of cases of cyanotic congenital heart disease, an incidence significantly higher than that found in the general population (less than 1 per cent)[7].

Submitted to the Publication Committee, December 5, 1963.

The Authors

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Awareness of this coincidence is required if the full potential for prevention or cure of brain abscess in cases of congenital heart disease is to be realized. The following case report illustrates the difficulty of diagnosis and treatment even when brain abscess is suspected, and emphasizes the need for preventive measures in all cases of congenital heart disease.

Case Report

The patient, an 8-year-old boy with known cyanotic congenital heart disease, had complained of malaise and headache for 15 days. A left-sided Jacksonian seizure followed by progressive left hemiparesis prompted his immediate hospitalization.

Examination revealed a thin, slightly cyanotic, drowsy and acutely ill boy. Temperature 99.2 F. Other vital signs were normal. A grade IV, harsh systolic murmur was best heard along the left sternal border at the level of the 2nd and 3rd inter-

costal spaces. The second sound in the pulmonic area was decreased; no thrill was noted. A thoracic roentgenogram revealed decreased pulmonary vascular markings, a prominent aortic segment, and concavity of the pulmonary artery segment which, with the clinical findings, strongly suggested the diagnosis of tetralogy of Fallot.

Neurologic examination revealed the following abnormalities involving the left side: hemiparesis, hypoesthesia, hyperactive deep tendon reflexes, presence of Babinski's sign and central facial paralysis. Bilateral papilledema and right rotary nystagmus were present. The left pupil was larger than the right; both reacted to light and accommodation sluggishly, and mild consensual narrowing of the visual fields was present. The remainder of the neurologic examination was within normal limits. Roentgenograms of the skull revealed no abnormality except for poor aeration of the left mastoid cells. Lumbar puncture on admission was normal as was the case in one performed 3 days later.

Because the patient had known cyanotic congenital heart disease and his lateralizing neurological symptoms persisted, a brain abscess was suspected and a right carotid arteriogram was performed (Figure 1). Anteroposterior views revealed lateral displacement of the anterior choroidal artery around a deep medial mass, slight lateral displacement of the right anterior cerebral artery and prominent displacement of the right middle cerebral group. Lateral views showed a wide posterior sweep of the anterior choroidal artery, elevation of the middle cerebral artery and anterior displacement of the anterior cerebral artery. These findings were consistent with slight enlargement of the right lateral ventricle and a space-occupying thalamic lesion, most likely a brain abscess.

Vigorous antibiotic therapy was instituted. Seven days after admission, meningeal signs developed and a third lumbar puncture was performed. The cerebrospinal fluid contained 1,800 white cells (75 per cent polymorphnuclear leukocytes and 25 per cent lymphocytes); the total protein was 93.6 mg. per cent. Hemolytic staphylococcus albus, coagulase negative, was cultured from the spinal fluid. Antibiotic therapy was adjusted per sensitivity studies. Three subsequent cerebrospinal fluid cultures were nega-

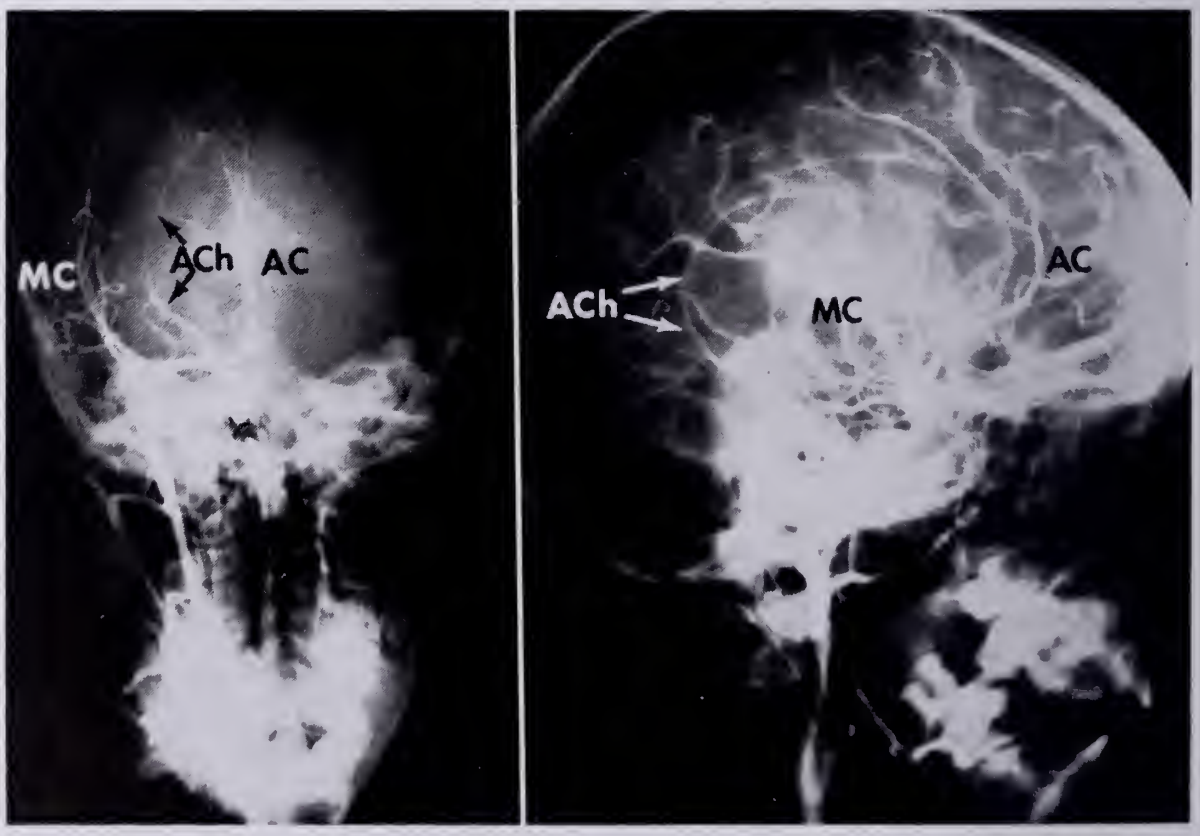

Figure 1. Right carotid angiogram. (Left) Anteroposterior view. Opaque has entered carotid artery and opacified its branches. Anterior cerebral artery (AC) is bowed slightly toward midline. Middle cerebral group of arteries (MC) is displaced laterally. Anterior choroidal artery (ACh) is displaced laterally around a deep, medial space-occupying lesion. (Right) Lateral view. Anterior cerebral artery (AC) is displaced anteriorly. Middle cerebral group of arteries (MC) is slightly elevated. There is dramatic posterior displacement of anterior choroidal artery (ACh). Findings indicate enlargement of right lateral ventricle and a large, space-occupying lesion in area of thalamus.

tive. Despite antibiotic sterilization of the cerebrospinal fluid, the patient's course was progressively downhill.

Needle aspiration of the abscess 27 days after admission yielded approximately 35 ml. of thick, green pus. Aqueous penicillin was introduced into the abscess cavity. The patient improved. Approximately one week postoperatively, however, he suddenly became semicomatose. Recurrence of the brain abscess was suspected, and a second needle aspiration was attempted which yielded no pus. His condition became worse, signs of increased intracranial pressure ensued and, despite continued antibiotic and supportive therapy, he expired.

At necropsy, abnormalities were limited to the cardiovascular and central nervous systems. Examination of the heart (Figure 2) revealed evidence of right ventricular hypertrophy. The great arteries were normally interrelated and the aorta was larger than the pulmonary artery. A large (1.5 cm) ventricular septal defect was present in the membranous septum. Marked hypertrophy of the crista supraventricularis and its septal and parietal bands produced significant narrowing of the ostium infundibulum. Additional significant narrowing was present at the level of the pulmonary valve which was bicuspid. The coexistence of obstruction in the pulmonary outflow tract and a ventricular septal defect resulted in a right-to-left shunt at ventricular level. This is one of the combinations of defects classified as tetralogy of Fallot. In addition, a small (4 mm.) atrial septal defect of the secundum type was present.

Examination of the brain revealed it to be grossly edematous and markedly softened, with flattening of the convolutions and near obliteration of the sulci. Two distinct brain abscesses were present (Figure 3). The first was a large, chronic, encapsulated abscess measuring 4 by 1.8 cm. It began in the right midoccipital lobe and extended anteriorly to the frontoparietal junction. This chronic abscess, containing a whitish-green purulent exudate, completely obliterated the thalamus on the right side and produced marked shifting of the midline structures toward the left. It produced marked compression of the anterior portion of the right lateral ventricle and almost complete occlusion of the foramen of Monroe. The corona radiata were displaced laterally and the internal capsule inferiorly. Anterior to the abscess was an area of encephalomalacia.

The second abscess was acute, involving the brain tissue immediately surrounding the occipital and temporal horns of the right lateral ventricle, which were markedly dilated and contained purulent material. It appeared that the acute abscess, involving the areas of brain contiguous to the occipital and temporal horns of the right lateral ventricle, was a consequence of rupture of the chronic abscess into the right lateral ventricle.

Discussion

The features illustrated in this case, for the most part, are typical of brain abscess complicating cyanotic congenital heart disease. Discussion and further amplification of some of the points follow, under three headings.

I. Etiology of Brain Abscess

Brain abscesses occasionally result from the direct extension or retrograde lymphogenous extension of a nearby focus of infection. Penetrating head injuries, purulent otitis or mastoiditis, purulent sinusitis and similar acute infections involving the head and face are examples. The ease of recognition of these infections almost invariably alerts the physician to the possibility of brain abscess when abnormal neurologic symptoms occur.

More common are brain abscesses resulting from septic emboli from distant foci of infection. Two factors are involved in the pathogenesis of these occult brain abscesses (Figure 4). First, the septic emboli must by-pass the filtering action of the lung. Second, the septic emboli must reach an area in the brain in which there is preexisting cerebral damage. The work of Malenovski[8] established that simple implantation of organisms in any quantity by direct inoculation of the brain or via the blood stream will not result in the formation of a brain abscess. Groff[9] extended this work using cats as experimental animals. The brain or its blood supply was injured and encephalomalacia resulted. Subsequent to the development of encephalomalacia, implantation of organisms, either directly or via the blood stream, resulted in brain abscess.

This theory of etiology of brain abscess provides an explanation of its high incidence in children with cyanotic congenital heart disease. These children are hypoxic, and chronic cerebral hypoxia alone may result in nonspecific changes in the cerebral tissue[10]. Chronic hypoxia also produces secondary polycythemia. While the polycythemia compensates to some extent for hypoxia, the high hematocrit predisposes to sluggish circulation and to sludging of blood in the small vessels, with resultant focal cerebral infarction and softening. Furthermore, the right-to-left shunt present in these children allows par-

adoxical emboli to lodge in the brain, with resultant encephalomalacia. These damaged areas of cerebral tissue become fertile ground for the implantation and growth of bacteria.

Not only is the right-to-left shunt responsible for the production of a suitable environment for the propagation of pathogenic organisms in the brain, but it also allows organisms to by-pass the filtering action of the lungs. It is well known that transient bacteremia commonly occurs during and following dental procedures and during episodes of respiratory infection, tonsillitis, pharyngeal abscess, urinary tract infection and manipulation, and other infections. In the normal case the resulting organisms are filtered in the lung. In the case of the patient with cyanotic congenital heart disease, however, the organisms may pass with the venous blood directly from the right side of the heart into the systemic circulation, thus by-passing the lungs. Once in the systemic arterial circulation, the organisms may reach the previously damaged areas of the brain in sufficient quantity to produce an abscess.

II. Diagnosis of Brain Abscess

The signs and symptoms of brain abscess in the case of the patient with congenital heart disease are no different from those seen in brain abscess in general. The presence, however, of cyanotic congenital heart disease should alert the physician to the possibility of brain abscess. *The child with cyanotic congenital heart disease and abnormal neurologic signs or symptoms has a brain abscess until proven otherwise.*

The signs of infection in these patients may be subtle. As in the reported case, fever seldom is prominent. In most cases, an initial source of infection is impossible to demonstrate and blood cultures are consistently negative. The white blood count and differential may or may not reflect the infectious process.

The signs of neurologic damage are dependent upon the area of brain involved. Those most often reported are lateralizing motor signs, aphasia, hemianopsia and convulsions. Convulsions are seen rather consistently and may be localized, as

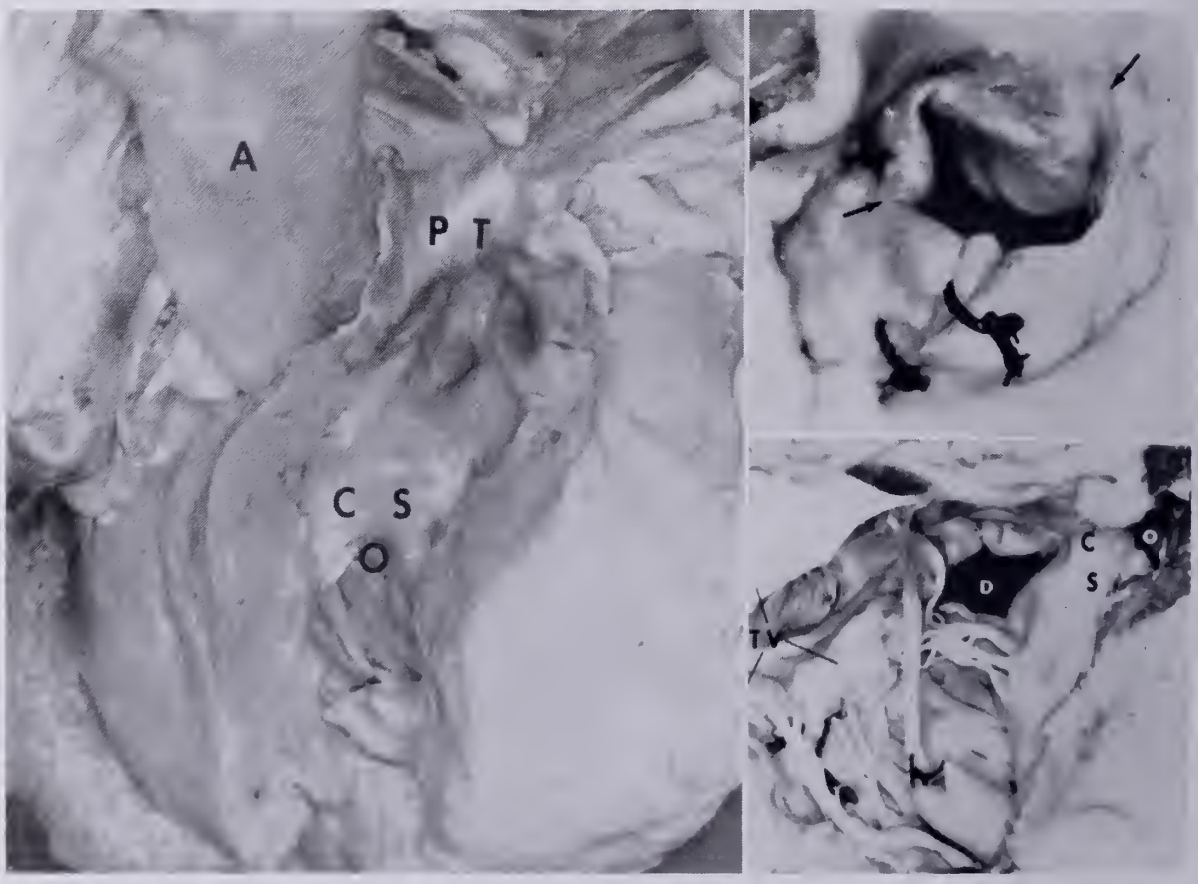

Figure 2. (Left) Heart is viewed from in front through an incision in anterior portion of right ventricle and pulmonary trunk (PT). Marked hypertrophy of crista supraventricularis (CS) and its septal and parietal bands has produced narrowing of ostium infundibulum (O). Right ventricular wall is thicker below level of ostium infundibulum than above. Diameter of aorta (A) is approximately twice that of pulmonary trunk. (Right Upper) Bicuspid pulmonary valve viewed from above. Leaflets are markedly thickened and there is fusion of commissures (arrows) resulting in a pulmonary valve orifice approximately ¼ the size of the pulmonary valve ring. (Right Lower) Interior of right ventricle viewed from below. Tricuspid valve is to the left and crista supraventricularis (CS) and ostium infundibulum (O) to the right. Large ventricular septal defect (D) is posterior to crista supraventricularis and immediately below origin of aorta. Right and posterior aortic cusps are protruding into ventricular septal defect at its upper margin.

in the case presented, or generalized. In Matson's series of 13 cases,[11] localized seizures were seen most frequently. The convulsions, when present, usually occur early in the course of the illness. Headache is a constant finding, appears early, usually is severe and progressive and is not responsive to symptomatic therapy. Signs of increased intracranial pressure occur in most cases at some time in the course of the illness.

The cerebrospinal fluid often is completely normal, as it was early in our patient's course. Slight increase in pressure, a few white cells or mild increase in protein may be present but these are of limited diagnostic value. Cultures of the cerebrospinal fluid are negative unless rupture of the abscess into the ventricular systems has occurred. Once the abscess has ruptured into the ventricular system, signs of meningitis ensue

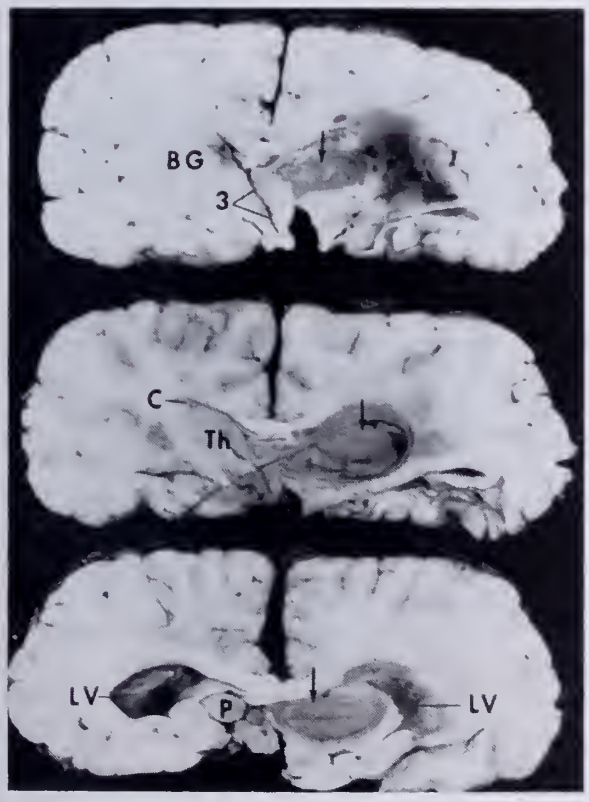

Figure 3. Coronal sections through brain viewed from behind. (Top) Coronal section through frontal lobe and basal ganglia. Chronic encapsulated abscess (arrow) has ablated right basal ganglia and caused pronounced shift of midline structures to the left. Hemorrhage is seen in fresh abscess to right of chronic abscess in corona radiata and subcortical white matter. (Center) Coronal section through parietal lobe, posterior portion of thalamus and tail of the caudate nucleus. Extension of encapsulated abscess has completely replaced thalamus in this region. There is prominent shifting of midline structures to the left. Subcortical white matter surrounding encapsulated abscess shows softening and degeneration. (Bottom) Coronal section through posterior parietal lobe and nucleus pulvinaris of the thalamus. Chronic encapsulated abscess has completely ablated nucleus pulvinaris on the right (arrow). Right lateral ventricle at this point also is filled with purulent material, indicating rupture of abscess into ventricular system at this site. Midline structures are shifted to left. TH = thalamus. P = nucleus pulvinaris. C = tail of caudate nucleus. 3 = third ventricle. L.V. = lateral ventricle. BG = basal ganglia.

and the cerebrospinal fluid findings confirm this. These are late signs, however, and herald an ominous prognosis.

Occasionally in long-standing brain abscess roentgen signs of increased intracranial pressure are noted on routine skull roentgenograms. The electroencephalogram sometimes records slow wave high voltage foci. Ventriculography or pneumoencephalography may aid in the precise localization of the abscess. Carotid arteriography often is a highly satisfactory method of localizing this space-occupying lesion.

III. Treatment

Cardiovascular Surgery.—Complete correction of the cardiac defect practically eliminates the occurrence of brain abscess. This consideration encourages the performance of corrective surgery in older children with tetralogy of Fallot and other defects now amenable to surgical care.

In many cases, however, the cardiac defect, e. g., transposition of the great vessels, is not at present curable surgically or, though curable, carries an unduly high risk, e. g., tetralogy of Fallot. Currently, palliative cardiac operations such as the Blalock-Taussig anastomosis still provide the best available therapy in these cases. It is important to recognize that these palliative procedures, while they improve cardiac hemodynamics, will not prevent the possibility of brain abscess.

Prophylactic Antibiotic Therapy.—In the patients with inoperable defects, and those patients who are waiting for a more optimal time for corrective surgery, prophylactic antibiotic therapy is directed to elimination of the transient showers of bacteria. Penicillin is the prophylactic drug of choice during dental procedures, including extractions, filling of the teeth and gingival surgery, during tonsillectomy and adenoidectomy, other ENT procedures, and incision and drainage of abscesses. The authors use 600,000 units of procaine penicillin the day prior to surgery and 600,000 units of aqueous penicillin with 600,000 units of procaine penicillin at the time of the procedure. A second prophylactic regimen, if injection is not feasible, is oral penicillin G, 250,000 units four times daily for five days, beginning two days prior to the procedure. In cases of penicillin sensitivity, erythromycin or a broad spectrum antibiotic may be employed.

Bacteremia may occur also in patients undergoing surgery or manipulation of the urinary tract or lower gastrointestinal tract. A broad spectrum antibiotic should be administered for

a total of five days, starting two days preoperatively.

Any bacterial infection may result in transient or persistent bacteremia and should be vigorously treated with a bacteriocidal drug such as penicillin. Where possible, cultures should be performed and the antibiotic treatment altered according to established sensitivities. Therapy should continue for at least ten days or until there have been no signs of infection for three days.

Treatment of the Brain Abscess.—Once brain abscess has developed in the patient with congenital heart disease, it usually is of an acute character. Massive systematic antibiotic therapy should be instituted immediately. Aqueous penicillin in the neighborhood of 10,000,000 units daily and a broad spectrum antibiotic given in the maximal tolerated dosage should be continued for several weeks.

If the abscess can be localized either by clinical symptoms or signs or by specialized diagnostic procedures, surgical draining utilizing a brain needle should be added to the systemic treatment. Instillation of a radiopaque material at this time allows the size and location of the abscess to be monitored roentgenographically. Aspiration should be repeated as often as indicated clinically. If the abscess is approachable via craniotomy, it may be removed surgically after a period of antibiotic therapy and subsequent to needle aspiration. It is generally thought to be efficacious to instill small amounts of antibiotics in the abscess cavity after aspiration or into the defect following surgical removal of the abscess. The effectiveness of surgical treatment, either aspiration or surgical removal, is enhanced by the fact that a single abscess is present in the great majority of cases (37 of 40 cases reported by Cohen et al).[12]

Definitive treatment of the brain abscess in the case presented was made difficult by the remote and nearly inapproachable location of the abscess and by its spontaneous rupture into the right lateral ventricle.

Summary

A case of tetralogy of Fallot and brain abscess in an 8-year-old boy is reported.

The high incidence of brain abscess in patients with cyanotic congenital heart disease is explained by (1) the predilection for occurrence of areas of encephalomalacia in these patients and (2) an abnormal cardiovascular pathway which allows bacteria to by-pass the filtering action of the lungs and lodge in the damaged brain.

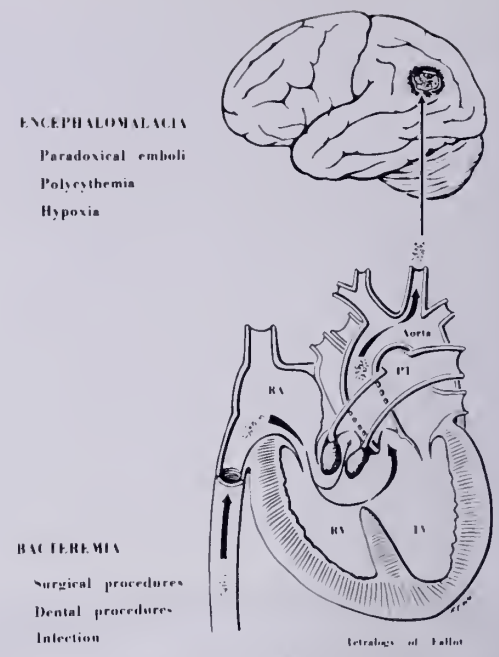

Figure 4. Etiology of brain abscess in cyanotic congenital cardiac disease. Two factors coexist in the genesis of brain abscess: (1) Bacteria reaching the blood stream by a variety of mechanisms (lower) must by-pass filtering action of lungs and (2) bacteria must reach an area of damaged brain tissue or encephalomalacia (upper). Cyanotic cardiac defect not only allows bacteria to by-pass lungs but prepares the brain, as indicated, for their nurture.

The clinical features of brain abscess are considered; prevention and treatment are discussed.

Abnormal neurological signs or symptoms in the case of the patient with cyanotic congenital heart disease signify brain abscess until proven otherwise.

Acknowledgment

For their assistance in the preparation of this manuscript, the authors wish to thank David F. Bell, Jr., M. D., Department of Pathology, Bluefield Sanitarium, Bluefield, West Virginia; Ralph E. Haynes, M. D., Bluefield; G. Robert Nugent, M. D., Assistant Professor of Surgery, West Virginia University School of Medicine; and Robert J. Johnson, M. D., Professor and Chairman of the Department of Anatomy, Graduate School of Medicine, University of Pennsylvania.

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Our Position on the King-Anderson Bill

We've been asked on several occasions how we felt about the present effort of the Johnson Administration to force a medical care plan based on one-half of one per cent increase in the Social Security rate. Frankly we're against it and we feel that we are on solid ground in taking this stand.

At the outset, let us hasten to point out that we are not in the least opposed to some sort of subsidized medical care for those who cannot otherwise afford it. Illness is no respector of persons and sooner or later it has a bad habit of getting around to all of us in one form or another. From what we can learn after some detailed inquiry, the present Kerr-Mills provides for this care without cost to the participant and does so on the basis of need.

Now, however, the ugly head of enforced bureaucracy rears itself in the form of what is known as the King-Anderson Bill which would force all of us to participate, even though many would have health care programs of their own or could readily pay for it out of their own funds. This bill is known as H. R. 3920 and would, regardless of need, force us to pay not only for our own medical services, but others as well even though we are presently spending staggering sums of money to take care of the medically indigent.

It seems that it is now common practice for the federal government to formulate plans and apply them all over the country whether desired or needed and this is what we believe the King-Anderson Bill proposes to do.

We are opposed because we feel that Kerr-Mills is presently adequate. We also are not so naive as to believe that a program of this magnitude can be financed with the slight increase in Social Security Rates as stated above. Our own opinion, for what it is worth, is that this is just an opening wedge and that when such a proposal gets going, Social Security rates would soar to the place where they would be prohibitive. We further oppose it on the grounds that the government in the past has shown no inclination to eliminate the chiselers as it has done in so many of its other "do-good" programs. A further objection is that as a small business owner and operator this is just another bite of tax money that the Federal Government would be taking for the purpose of buying votes.

The time has long since passed when the small marginal businessman and farmer can stand the ever increasing burden of taxation, no matter how innocently applied, and this bids fair to be one of the biggest boondoggles yet.

If you would prefer to buy your own medical plan or to pay for it yourself without having to pay for that of every other person, deserving or not, it's time to write your congressman and tell him so. Tell him that it just might be possible that if enough small shopkeepers are forced to close their doors because they are forced to support the sinister hand of the federal government and its hunger for more and more taxes, the time may come when nobody will be left to pay.—*Grant County Press.*

Intra-Epithelial Carcinoma of the Cervix and Pregnancy*

Joseph C. Parker, M. D.

THE advent of the Papanicolaou smear has, as it should have, increased generally physicians' awareness of the possible occurrence of all forms of cervical cancer in pregnancy patients. If progress is to be made in the treatment of cancer, early diagnosis, particularly while the disease is in the pre-invasive state, is the *sine qua non* in management. There is no better source for screening cases of early malignant conditions than the prenatal patient. The Papanicolaou test is well established and documented as a valuable means of early detection of carcinoma of the cervix. It has been hailed by several authorities as the greatest single gynecological contribution of the century. There still are many obstetricians and gynecologists, however, who apparently question the efficacy of the test in pregnant patients. Their doubt probably is due largely to the confusion of some cytologists and pathologists concerning the usual cervical changes in pregnancy.

Table 1

Intra-Epithelial Carcinoma of the Cervix And Pregnancy 1960-1962

Patient Visits (New Patients and Checkups)	5,971
New Pregnant Patients	972
Number of Papanicolaou Smears	3,253

Table 2

Intra-Epithelial Carcinoma of the Cervix And Pregnancy 1960-1962

		%
Total Papanicolaou Smears	3,253	100
No. of Pregnant Patients	972	30
No. of Positive Smears	4	0.12
No. of Suspicious Smears	13	0.4
No. of Abnormal Smears	17	0.5

Table 3

Intra-Epithelial Carcinoma of the Cervix And Pregnancy 1960-1962

		%
No. of Pregnant Patients	972	100
No. of Positive Papanicolaou Smears	2	0.2
No. of Suspicious Papanicolaou Smears	4	0.4
No. of Abnormal Papanicolaou Smears	6	0.6

*Presented before the Eighth Annual Potomac-Shenandoah Valley Postgraduate Institute in Martinsburg, October 27, 1963. Submitted to the Publication Committee, November 5, 1963.

The Author

- **Joseph C. Parker, M. D., Associate Professor of Clinical Obstetrics and Gynecology, Medical College of Virginia, Richmond.**

It should be remembered that the Papanicolaou test is chiefly a screening mechanism rather than an absolute diagnostic tool. In other words, the positive or suspicious Papanicolaou smear always should be corroborated or refuted by tissue study. The hesitancy of some obstetrician-gynecologists to perform knife cone biopsy of the cervix in the pregnant patient probably further explains their hesitancy with regard to routine screening of pregnant patients by means of the Papanicolaou smear.

Incidence of pre-invasive or intra-epithelial lesions of the cervix varies with the individual investigator. Kistner and his associates estimate that of every 2,000 pregnant patients one (0.05 per cent) will have cervical cancer. Marsh and Fitzgerald, from a study of cervical biopsy specimens from 4,000 pregnant patients, reported 2 cases of invasive carcinoma, an incidence of (0.05 per cent), and 20 cases of carcinoma *in situ*, an incidence of 0.5 per cent. On the other hand, Holzaepfel and Ezell, in a study of pregnancy complicating carcinoma of the cervix, reported 28 cases of pregnancy in 925 cases of carcinoma of the cervix. Kromer and Hawken reviewed 860 case histories of pelvic cancer and found 20 cases of carcinoma of the cervix in pregnant women. My colleague and I, in our private practice, have found 2 cases of intra-epithelial carcinoma of the cervix in 972 pregnant patients over a 3-year period, an incidence of 0.2 per cent. During this same period we found one case of invasive carcinoma of the cervix, an incidence of 0.1 per cent.

Papanicolaou Smear is Routine

It is routine in our practice to obtain a Papanicolaou smear in the case of each pregnant patient on her first visit to the office. The same rule applies to gynecological patients who have not had the benefit of such a test within the past 12 months. We try also to repeat the smear at

least once every 12 months. Our patients are instructed to return for gynecological checkup at 6-month intervals.

During the years 1960 to 1962 inclusive, there were 5,971 patient visits to our office, exclusive of return prenatal visits. Three thousand two hundred fifty-three (3,253) Papanicolaou smears were obtained on these patients, of which number 972 were first-pregnant visits. Of the 3,253 smears, 4 were positive and 13 were suspicious, as reported by our pathologist. Two of the 4 positive as well as 4 of the 13 suspicious smears were those of pregnant patients.

A positive or suspicious Papanicolaou smear is first checked by a repetition of the test. If the second test corroborates the first, the patient is hospitalized and a knife cone biopsy specimen is removed at the squamocolumnar junction.

Of the 13 suspicious Papanicolaou smears in pregnant patients mentioned above, there were 2 cases of squamous metaplasia, 1 case of chronic cervicitis and 1 in which a repeat test on two occasions was reported as normal or Class I. In the 2 positive (Class IV or V) cases, knife cone biopsy revealed intra-epithelial carcinoma.

One of the 2 patients was a 41-year-old G VI, P IV, A I, first seen at the twentieth to twenty-second week of pregnancy. The pregnancy had been essentially uneventful, there being no untoward signs or symptoms of any type. The cervix appeared eroded and everted, and there was a moderate mucopurulent discharge. Both the initial and the repeat Papanicolaou smears were reported as positive for tumor cells. The patient was hospitalized and a knife cone biopsy performed, the result confirming the suspected diagnosis. Repeat smears following the knife conization were reported as negative. Her pregnancy progressed uneventfully until about the thirty-second to thirty-fourth week, when she spontaneously delivered a premature male infant via the vaginal route. The infant weighed 4 pounds, 4 ounces and is now living and well. When she returned for her 6-week checkup postpartum, the Papanicolaou smears were reported as negative, and multiple punch biopsies of the cervix revealed chronic cervicitis. In view of her age, parity and immediate past history, she was subjected to total abdominal hysterectomy and appendectomy ten weeks following delivery. Pathological examination of the specimen revealed no residual malignancy.

In the second case, the patient was a 36-year-old G. II, P. O, A. I, first seen at six weeks' gestation. Both the initial and repeat smears were reported as positive. Knife cone biopsy of the cervix revealed definite carcinoma *in situ* and leukoplakia. The patient was carried to term uneventfully and delivered, by means of low midforceps, of a living male child in good condition. A second repeat smear at her six-week checkup revealed the same type of cells as formerly. A second biopsy confirmed the presence of carcinoma *in situ* and leukoplakia. Hence, total abdominal hysterectomy and appendectomy were performed approximately ten weeks following delivery. Pathological examination of the specimen revealed intra-epithelial carcinoma.

The Ideal in Tests

There can be little doubt that a test as simple to perform and as effective a screening mechanism as the Papanicolaou test has proven to be, with no harmful effect on the patient, is of inestimable value in the pregnant as well as in the nonpregnant patient. So long as its limitations are clearly recognized by those using and interpreting it, only good can come of its application. The clinician must know well his pathologist's interpretation of the smear in order to evaluate his report. In the case of the questionable smear, frequent consultation between pathologists should be insisted upon by the responsible clinician. Tissue study confirmation, of course, is mandatory before any therapy or lack of therapy is instituted.

Knife cone biopsy of the pregnant cervix should not be feared and it is essential for the completeness of the diagnosis. Hemorrhage is, of course, an ever present threat, but this usually can be readily and easily controlled. In many instances, simple cauterization of visible bleeding points with the ball point tip of the high frequency cold cautery will control the blood loss. This has not resulted in any harm to the pregnancy in my experience. Injection of the cervical tissue with weak adrenalin solution prior to the knife cone biopsy has been advocated by several authorities. Others suggest suture ligature of the cervical branches of the uterine arteries. Each case, however, must be individualized and the procedure or procedures necessary to meet the exigencies of the situation employed.

There is no longer any excuse for women in this country dying of carcinoma of the cervix uteri. These deaths can be eradicated by early diagnosis of these malignant lesions before they become invasive. Prenatal patients who have not had the benefit of a Pap smear have been incompletely studied and when suspicious or positive cells are discovered in these smears, appropriate diagnostic methods can and must be employed to rule out malignancy.

Treatment Varies

When the diagnosis of intra-epithelial carcinoma has been clearly established and, in my opinion, this can be accomplished by an adequate cone biopsy of the cervix, treatment will vary with the situation. In general, however, vaginal delivery can be anticipated unless there is some obstetrical contraindication. The ultimate decision as to hysterectomy in the postpartum state will depend on the patient's age, parity and other factors that may govern a particular case.

In dealing with invasive carcinoma of the cervix of whatever stage, in the face of pregnancy, the type of management becomes vastly different. In this situation the disease process should be vigorously treated and the pregnancy more or less ignored depending, of course, on the stage of the pregnancy at the time the diagnosis is established.

Summary

In summary, a plea is made for routine and widespread use of the Papanicolaou test at regular intervals, at least yearly, in all female patients. The prenatal patient especially should be included, since such cases afford us an opportunity to pick up an occasional unsuspected malignancy of the cervix uteri at a time when cure can be effected. Adequate follow-up of suspicious and positive smears is essential for institution of proper and effective treatment. At the present time, it is only through early diagnosis that proper management of cervical cancer and other malignancies becomes possible.

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Facing Up To Spring

CUSTOM and calendars to the contrary, Spring really marks the beginning of a new year. It is, incontrovertibly, the time of the year most encouraging of hope. In the cycle of seasons, after the gloom and cheerless cold of Winter, Spring comes, warm of touch and sweet of breath, to renew the beauty and vitality of nature and to encourage men and women everywhere to dream and to do.

In Spring, farmers plow under the detritus of their previous crops. With eager effort they prepare for new and better plantings and look forward, lessoned by experience, to better harvests than they yet have known. As with farmers, so with us all. Spring invites us to bury what is past and to build anew what is to be. In our private lives we are given the opportunity to plan and work for the products that the new year is to bring forth. In the genial light of returning Spring we are encouraged, with hearts undaunted by what has gone before, to rededicate ourselves to our dreams and our hopes, and to work for their fulfillment. Two things are needed—the courage to begin again and the stamina to persevere.

As with individuals, so with peoples. If in the year gone by, in professional, political, and social fields the crops that we raised and the harvests that we gathered were disappointing and unrewarding, now is the time to learn from our mistakes and to enter upon a work of wholesome husbandry. Only those who have abandoned dreams and have embraced the death of hope are beyond the revitalizing reach of Spring. But to all others—energized and sustained by faith in God, in themselves, and in their fellowmen—Spring calls . . . to new life, new hopes, and new effort.

What if it has been a Winter of dark discontent? The Winter is past and gone. Now, with liting hearts and minds, let us face the Spring!—Membership News Letter, The Medical Society of New Jersey.

Diospyrobezoar

George E. Farrell, M. D., and Robert G. Shirey, M. D.

THE bezoar may be divided into three categories: (1) trichobezoar, which is composed of ingested hair, (2) phytobezoar, due primarily to ingestion of vegetable fibers and (3) diospyrobezoar, caused by ingestion of persimmon seeds (genus Diospyros). Cases of trichobezoar usually are seen in patients in mental institutions, while phytobezoar and diospyrobezoar may occur in persons of normal mentality, as evidenced by the following case report:

Case Report

A 73-year-old white male first was seen on December 7, 1961, with cramping, peri-umbilical, abdominal pain unaccompanied by vomiting and diarrhea. According to the patient, the pain had been present since he had eaten persimmons, including the seeds, four days prior to his visit. There was no evidence of hematemesis nor of melena.

Physical examination was negative except for tenderness of the epigastrium to palpation. He was placed on Donnatol and a mixture of bella donna alkaloids. A soft, bland diet was prescribed.

He returned on January 4, 1962, stating that the epigastric pain had become more severe and of longer duration. The abdomen again was extremely tender to palpation. At this time, a stool specimen was positive (2 plus) on a benzidine test. He was referred to this hospital on January 5 for a gastrointestinal x-ray series.

Radiographic findings were reported as follows: "There is a well-defined, fixed filling defect in the antrum of the stomach, which is irregular in shape. It measures 4.5 by 3 cm. The barium is smooth along the superior and proximal margins. There is another poorly defined, fixed filling defect in the *pars media* of the stomach, which is also irregular in shape. It measures 4.5 by 5 cm. There is a well defined crater along the lesser curvature posterior wall of the stomach, which measures 2 by 1.4 cm. The edges of the ulcer are slightly irregular. Conclusion: The most likely diagnosis is a malignant polypoid mass of the stomach with ulceration. The possibility of a benign ulcer with clotted blood seems less likely."

Submitted to the Publication Committee, November 14, 1963.

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The patient was placed on an ulcer diet for two weeks and returned on January 19, 1962, for repeat gastrointestinal series. Radiographic findings were the same with regard to the filling defects. The ulcer, however, had decreased in size. In spite of this, it was believed that malignancy was the most likely diagnosis and that surgical intervention was indicated.

Figure 1. Film of stomach taken on January 5, 1962, during initial examination, showing a well-defined, irregularly shaped, fixed, 4.5 by 3 cm. filling defect in antrum. Barium is smooth along superior and proximal margins. There also is a poorly-defined, irregularly shaped, fixed, 4.5 by 5 cm. filling defect in the pars media. There is a well-defined crater along the lesser curvature posterior wall, measuring 2 by 1 cm. Edges of ulcer are slightly irregular.

Figure 2. Blown-up spot film of stomach taken on January 5, 1962, during initial examination, showing ulcer described in Figure 1. Filling defects also are visualized.

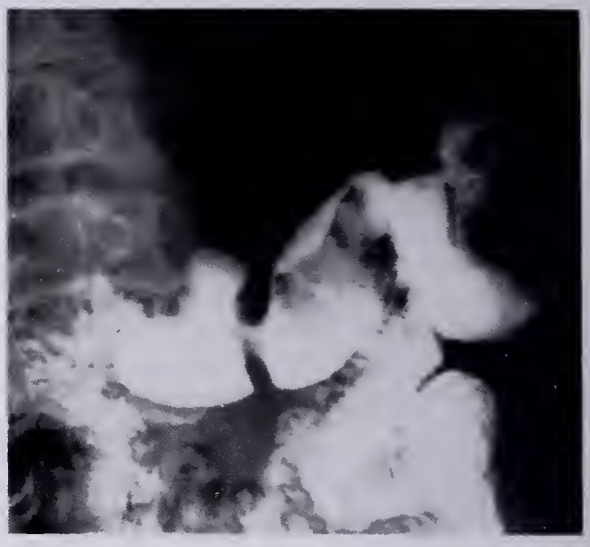

Figure 3. Radiograph of stomach taken on July 19, 1962, during follow-up and final examination. Filling defects remain unchanged; the ulcer, however, has decreased in size.

The patient elected to enter a Veterans Hospital. Its laboratory findings were as follows: Urine—within normal limits. Hemoglobin normal, RBC 4,130,000, hematocrit 38.5 vol. per cent. Gastric analysis with histamine showed free hydrochloric acid in all specimens. VDRL was nonreactive. Chest x-ray was within normal limits.

On surgical exploration, January 31, 1962, it was found that the gastric ulcer had healed. Following gastrotomy, a foreign body measuring approximately 7.5 by 5 cm. was found in the stomach. It was removed and the stomach was closed. The patient did very well postoperatively and was discharged on February 19.

Microscopic examination of the specimen was reported as follows: "Sections of the amorphous mass reveal vegetable fibers that are necrotic." Final report was "Phytobezoar of stomach; operated, improved."

Discussion

A case of persimmon bezoar is presented.

The common persimmon is a sweet-tasting plum-like fruit containing multiple flattened, oblong seeds approximately 1 cm. in length. It is high in gum and pectin content. Apparently when persimmon is eaten with fibrous food, a bezoar may form in the stomach. It has been suggested that hydrochloric acid plays a part in the bezoar formation.

When a constant filling defect is noted in the stomach of a patient in a mental hospital undergoing a gastrointestinal series, the diagnosis of trichobezoar is considered. As can be seen from the present case, diospyrobezoar, although rare, also must be considered when a filling defect is discovered.

A bezoar may appear (as in our case) as a large, continuous mass or it may appear as several masses. It may extend into the esophagus,[3] duodenum or jejunum, or it may be found even in other parts of the intestine.[6,7]

Complications, Signs and Symptoms

The most common complication of bezoar is gastric ulcer, single or multiple. Several factors may be involved. Retention, of course, may be a factor. Actual erosion of the gastric mucosa by the bezoar probably is a major cause.

These putty-like masses, which vary in size, may be palpable. Signs and symptoms vary greatly. Within 24 hours of the ingestion of the persimmon, symptoms of an acute abdomen may appear. Incidence of nausea and vomiting varies. In some cases, weight loss, diarrhea or constipation may be present, suggesting malignancy.[5] Cases of severe hemorrhage due to associated gastric ulcer have been reported.[8,11,12]

Findings on roentgenologic examination will vary. One or several filling defects will be present in the fundus, *pars media* or antrum of the stomach. If the lesion is smooth and if there is ample room for the barium to surround it, a well defined filling defect will be seen. If a portion of the bezoar is adherent to the gastric wall, a partial filling defect or projection from the wall may be more noticeable. On the other hand, the lesion may be large, rough and adherent throughout. In such cases, mottling in the area will be observed rather than a clear-cut filling defect. If the surface of the lesion is irregular, what appear to be several filling defects may be seen.

If extreme mobility can be demonstrated in a large lesion by direct pressure or by changing the patient's position, the diagnosis of bezoar rather than polypoid malignancy should be favored. Gastroscopy, of course, is helpful in making the differential.[8]

In the case presented, there was a fixed lesion which had the appearance of several filling defects. For this reason, it was difficult to differentiate between bezoar and a large, polypoid malignant lesion.

Gastric ulcer or ulcers accompanying the lesion complicate the differential diagnosis. In our case there was a fairly large lesser curvature ulcer with the multiple filling defects, which certainly made us favor malignancy as the proper diagnosis. Even when the ulcer diminished in size we thought that the lesion was malignant, since the filling defects persisted.

Summary

A case of diospyrobezoar (persimmon bezoar) complicated by gastric ulcer is presented. It cannot be stressed too strongly that this diagnosis should be considered when one or several filling defects are discovered in the stomach with or without gastric ulcer. The vital point is that the condition conceivably could be considered inoperable carcinoma, with the result that the patient would not receive the benefit of surgery. Inasmuch as the lesion can be completely cured by surgery, failure to entertain the diagnosis of bezoar would be disastrous.[9]

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Knowledge That Moves

The imparting of knowledge that moves the patient to understand his ailment is part of the art and practice of medicine. When and how to tell the patient may make the real difference between progress or delay of recovery. In the case of serious or fatal illness, it may well ease the process of recovery, or the acceptance of finality.

Knowledge that moves the patient emotionally may elate or depress. The patient with a lump in the breast that turns out to be non-malignant is immensely relieved on receiving the information. On the other hand, the patient with a diagnosis of a malignancy can often be comforted by the manner in which the dread news is presented. The physician who acquires skill in giving this type of information is probably one of the most appreciated of individuals.

This imparting of information is an art. Some individuals have the naturally endowed gift. Others must acquire it in the hard school of experience. It is more than just words. It may be a look, a passing expression on a physician's face. The physician who takes the time to study this matter is more likely to be highly regarded in his community. Yet the truth behind the information given must never be belied. If one can place himself in the position of the patient, the knowledge that moves is more likely to be handled delicately and skillfully. We should take the trouble.—Massachusetts Physician.

Occupational and Household Allergy Due to Inhalants*†

Macy I. Levine, M. D.

RESPIRATORY tract symptoms due to inhalants encountered in the home and at work continue to present a major problem in diagnosis and management. In the case of the worker, occupational factors assume added significance with regard to Workmen's Compensation and continued employment. The purpose of this paper is to present current concepts of diagnosis and treatment in household and occupational allergy.

In a discussion of this subject it is essential to understand the meaning of allergy. Allergy, or hypersensitivity, refers to a body state of sensitivity to a specific substance, due to the presence of complex molecules called antibodies. Interaction of the antibodies with the specific substance (called antigen or allergen) results in the formation of intermediary substances and in the release of pharmacologically active chemicals such as histamine. These in turn produce the clinical signs and symptoms of the allergic disease. Thus, in order to recognize a clinical state as being of allergic origin, the physician must be able to associate the patient's symptoms with exposure to a particular substance to which his body previously has formed antibody. Occupational allergy refers to the occurrence of symptoms as the result of sensitivity to a substance associated with the patient's work. Household allergy, of course, refers to sensitivity to substances found in the home.

Sensitization to inhalants generally manifests itself in three clinical pictures: (1) conjunctivitis, characterized by lacrimation, itching and redness of the eyes, (2) rhinitis, characterized by sneezing, nasal discharge and obstruction and (3) bronchial asthma, characterized by paroxysmal attacks of wheezing, labored breathing and coughing. Rarely, urticaria from occupational inhalants has been reported.[1] Symptoms affecting the eyes, nose or bronchial tubes may involve only one of these sites but more often they occur in combination. Reliable statistics on the incidence of such symptoms from household or occupational factors are not readily available. Spain and Fontana[2] stated that the incidence of asthma in industry was 5 per cent, the same rate as that among the general population. Actually, the frequency of respiratory allergy varies greatly according to the occupation and depends largely on the nature of the substances to which the worker is exposed. It is well known that some materials are better sensitizers than others. Thus, certain occupations render an individual more prone to the development of allergic respiratory diseases[3] (Table 1). It may be of interest to point out that inhalants cause allergy in industry much less frequently than contactants.

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Table 1

Occupations Which Render the Worker Prone To Allergic Reactions of the Respiratory Tract

Baker
Stableman (and others exposed to horses)
Beautician
Barber
Farmer
Furrier
Janitor
Worker in bedding, furniture and silk industries
Worker in food industry
Brewer
Florist
Gardener
Hat-maker
Printer
Rag Sorter

Other Factors in Respiratory Tract Symptoms

In the home, house dust, feathers, various animal danders, atmospheric pollens and mold spores represent the important inhalant allergens. In industry, the list is much longer and includes animal danders, dusts from grains and other foods, pollens, molds and a variety of other materials. It must be remembered that factors other than allergy may cause respiratory tract symptoms. The former include chemicals, irritant dusts, fumes, tobacco smoke, infectious processes and psychological conflicts. In addition,

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allergic symptoms may be aggravated by infection, chemical irritation and emotional problems. Indeed, it would appear that there is a multiplicity of factors responsible for the development of the allergic disease. Furthermore, symptoms are not necessarily occupational in origin just because they began at work. This was well emphasized by a statement read at a recent medicolegal conference on lung disease and compensation:[4] "An ailment does not become an occupational disease simply because it is contracted on the employer's premises. It must be one which is commonly regarded as natural to, inhering in, and incident and concomitant of, the work in question. There must be a recognizable link between the disease and some distinctive feature of the claimant's job, common to all jobs of that sort."

Diagnosis

The most important diagnostic tool in allergy is the history. It must be thorough and detailed. The historical account of the symptoms tells the physician what the patient has, such as rhinitis or bronchial asthma. It is helpful in differentiating allergic asthma from chronic asthmatic bronchitis, which is a chronic inflammatory process of the bronchial tubes and which is also called intrinsic asthma or obstructive ventilatory disease of the lung. The history helps determine whether the clinical condition is of allergic or other origin. In other words, careful inquiry into the relation of the symptoms to exposure to specific substances tells the physician whether there might be sensitivity present. This is done by noting the patient's occupation and substances contacted at work, then asking about a possible correlation with these factors, or factors found at home. It is good practice to have a routine system of questioning about the allergens that commonly cause symptoms. The role of nonspecific factors should be noted. The physician should get to know something about the patient, his life and psychological milieu.

He should find out about those measures which provide relief of symptoms and the results of previous tests and treatment. A positive past or family history often is overemphasized in making an allergic diagnosis. This information should be used merely to alert the physician to consider an allergic basis for the patient's complaints, or possibly to help understand the pathogenesis of the illness. The diagnosis of allergy stands on the basis of the patient's history, the association of the symptoms with specific allergens and the presence of specific antibody, irrespective of the past or family histories.

The physical examination provides no pathognomonic signs of allergy. Pale, boggy nasal mucous membranes and inspiratory and expiratory musical rales are seen in nonallergic conditions as well as allergic states.

The Skin Test

In respiratory allergy the antibody involved is called the skin-sensitizing antibody. Its presence may be demonstrated by means of scratch or intradermal testing with specific allergens. When the history suggests a particular sensitivity, a positive skin test to the substance confirms the diagnosis. When the history provides no clues, skin testing to the most common allergens may provide leads to possible allergens. That is, should positive reactions be obtained in this case, the history should be reviewed and the patient's reaction to these materials noted. Further observation may be necessary in order to establish a definite diagnosis. Positive skin tests alone do not indicate sensitivity. False positive reactions occur frequently and render interpretation of skin tests results difficult.

Treatment

Treatment of allergic disease may be considered under four titles: specific, symptomatic, general and prophylactic.

Specific treatment deals with the cause. Optimally, the cause should be avoided. In the case of certain allergens which cannot be avoided, specifically house dust, pollens and molds, hyposensitization should be advised. Hyposensitization with animal danders often is unsuccessful, but in workers faced with the possibility of loss of employment it is worth a trial. Hyposensitization with bakery sweepings may be useful in bakers.

Symptomatic therapy includes the use of antihistaminic agents and decongestant drugs for eye and nasal complaints. Bronchodilators and expectorants comprise the basic drugs used for asthma. Other measures needed depend on the clinical state. Adrenal steroid therapy should be reserved for cases in which there is no response to standard treatment, or for cases where life is threatened or a useful existence is not possible otherwise.

General care involves attention to diet, other pathology present, emotional factors, and the like.

Prevention of allergic disease applies mainly to the industrial physician and consists of three facets: environment control, personnel protection and personnel selection. Environmental control involves the improvement and control of manufacturing processes in order to minimize contact with the materials used, and the substitution of safer materials for those known to sensitize. Personnel protection includes the use of protective clothing and proper ventilation. Personnel should be properly selected and placed in industry. In hazardous occupations workers may be rotated at periodic intervals to minimize exposure.

Summary

The nature of household and occupational allergy is defined. Current concepts in diagnosis and treatment are presented.

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We Would Call It Progress

A total of nearly $8 billion was invested by 140 million Americans in health insurance premiums in 1962, according to the annual survey by the Social Security Administration. This represented more than one-third of America's total medical care budget of $22 billion in 1962. While this budget total was up 5.8 per cent over 1961, health insurance payments increased 13.4 per cent, and direct payments for medical care rose only 2.2 per cent. The proportion of the total medical care dollar covered by health insurance benefits has increased steadily from a level of 8.2 per cent in 1948 to 31.1 per cent in 1962.

Per capita payments for health insurance amounted to $41.17 in 1962, up $4.33 from the 1961 level of $36.84 per capita. Total medical care expenditures per capita rose $4.93, from $114.51 in 1961 to $119.44 in 1962. Blue Cross and Blue Shield Plans accounted for 41.2 per cent of the nearly $8 billion total premium income, while 52.4 per cent was paid to insurance companies and 6.4 per cent to "independent" plans. The Blue Cross-Blue Shield share of total health insurance income has remained relatively stable at about 41 per cent ever since 1950.

Total benefit payments by all carriers amounted to $6.5 billion in 1962, or 86 per cent of premium income. The 75 Blue Shield Plans paid out 88.8 per cent of their total earned subscriptions in benefits during the same year. It is notable that while Blue Cross and Blue Shield "costs" or retentions have been decreasing (as a percentage of income) the cost ratio of the insurance companies, in aggregate, have been rising.

These figures suggest that the great challenge of the immediate future will be to improve the "quality" of Blue Cross and Blue Shield coverage, in terms of the proportion of total health care costs covered by the plans. And we may find that creating better protection for those now covered by our Blue Cross and Blue Shield Plans will provide the key to a new surge in the enrollment of those not yet covered by these Plans.

97TH ANNUAL MEETING

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AUGUST 20-22, 1964

Plan to Attend — Make Your Reservation . . . Now !

The President's Page

Guest Author, Mrs. Pat A. Tuckwiller, Charleston, President,
Woman's Auxiliary to the West Virginia
State Medical Association

THE Woman's Auxiliary to the West Virginia State Medical Association will celebrate its 40th Anniversary when we meet at The Greenbrier this August. Forty years ago you, the physicians of West Virginia granted permission to the doctors' wives so that they might have an organization to help in "the advancement of medicine and public health." This year our theme has been "Serve and Communicate." As Mrs. C. Rodney Stoltz, President of the Woman's Auxiliary to the American Medical Association, said in her remarks to the AMA House of Delegates, "It is our aim through this program to prepare our members to speak for medicine with knowledge and conviction, and to communicate with service, which will prove medicine's concern for the welfare of the community."

The 22 Auxiliaries in West Virginia have implemented this theme. While we do not want to lose our identity as an Auxiliary member, it may be that the most important Auxiliary contribution comes through our work as members of our church and community organizations where knowledge about health problems and programs and the call upon authoritative health materials is invaluable.

Although each Auxiliary is encouraged to meet the needs of its locality, many needs are general. All county Auxiliaries have been active in the efforts to preserve the heritage of American medicine. Letters were sent to Washington, speakers were provided for organizations, appearances were arranged on television, doctors' offices were stocked with pamphlets, and posters were put in strategic places.

Help has been given in the programs of Mental Health and speakers were provided in several communities. The film "Cry for Help" has been placed in the film library of the West Virginia Department of Mental Health. We hope many law enforcement and professional groups will make use of it in their training programs for suicide prevention. One Auxiliary is participating actively and financially in a class for retarded children. Vitamins were collected in one locality for indigent school children. Many individual members have helped in the projects most needed in their community. Another student will benefit from our Scholarship-Loan Fund again this year. A sizeable contribution will be made available to the West Virginia University Medical Center by our contributions to the AMA-ERF. The Health Careers Committees have conducted hospital tours and assisted in Career Days in the schools to interest junior and senior high school students in the many health careers.

It is with pleasure that I report these accomplishments to you. I have requested and received much help from the West Virginia State Medical Association. And now I have another request. The Auxiliary now has 1023 members or 71 per cent of our potential. If your wife is not a member will you encourage her to join the Auxiliary of your Society or to become a member-at-large? If there is no Auxiliary to your Society, we would be happy to help organize one. We need the enthusiasm and talents of every physician's wife to fully accomplish our program.

It has been a very real pleasure to serve as President of the Woman's Auxiliary to the West Virginia State Medical Association this year. May I take this opportunity to thank Dr. Charles L. Goodhand and our own Medical Advisory Board for the cooperation and guidance given me, and Mr. William H. Lively and Mr. Jerry Gould for their helpfulness throughout the year.

Carline H. Tuckwiller

THE WEST VIRGINIA MEDICAL JOURNAL

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EDITORIALS

WEREWOLVES AND MEDICINE

Myths or legends handed down throughout the ages generally pique the intellectual curiosity of the cultured man. When a myth appears to have some application to an obscure medical syndrome, it is likely that physicians will sooner or later explore it. The myth of the werewolf presently engages our attention.

Recently there appeared a scholarly essay by Illis in the *Proceedings of the Royal Society of Medicine* which summarizes some of the old myths concerning werewolves and the probable source of these early legends. In tracing the many accounts of werewolves that have been handed down to us, Illis tells us that legends of werewolves were familiar to such famous men as Pliny, Herodotus, and Virgil, and that like stories have been common in many lands.

Illis reminds us further that the term "werewolf" is probably derived from the Anglo Saxon "wer" meaning man and "wolf," and that the transformation may be brought about in several ways as by personal intent, the witchcraft of others, the devil or evil spirits, and even by a divine agency.

Since legends of werewolves are virtually world-wide, it would be hoped that descriptions of them would coincide, but their appearance is so variously described that Illis laments that it is difficult to build up a picture of a werewolf. He feels that the most consistent description would be a man (occasionally a woman or child) who wanders about at night. The skin of the face may be pale with a yellowish or greenish tint and the mouth noticeably red. A most striking feature is the numerous unsightly excoriations on the face, scalp and hands. The eyes are unsteady and behavior is abnormal.

Illis emphasizes that a belief as widespread both in time and place as that concerning the werewolf must have some basis in fact, and thinks that the majority of so-called werewolves were sufferers from congenital porphyria. In some detail he describes the remarkable relation between the signs of this dreadful disease and the many accounts of the appearance of werewolves that have come down to us.

Within the limits of this editorial only a few comments will be made on the symptomatology of congenital porphyria. The disease fortunately is rare and is due to a recessive gene. The resulting biochemical lesion is the inability of the body to convert porphobilinogen to porphyrin.

The disease is characterized by a severe photosensitivity resulting in a vesicular erythema. Ulcers may form on the face and hands, and these may attack cartilage and bones so that eventually the nose, ears, eyelids and fingers undergo progressive mutilation. Furthermore, hypertrichosis and pigmentation may develop on the photosensitive areas. Due to the deposition

of porphyrin the teeth may be red or reddish brown.

The condition is often accompanied by nervous manifestations which may range from hysteria to manic-depressive psychoses and delirium.

If the appearance of a person suffering from congenital porphyria and his abnormal behavior is compared to the descriptions of the so-called werewolf, the likeness is striking. It is no wonder that people who saw such a nightmarish and repulsive individual skulking about aimlessly in the dead of night would think of some supernatural being. Especially would this be true among uneducated, unenlightened and superstitious people.

Whether or not Illis is correct, could, of course, be debated, but his hypothesis is a stimulating one, especially to those trained in medicine. It may well be that as time passes other medical explanations will be offered for ancient legends which presently appear to be utterly groundless.

Illis, L., On Porphyria and the Aetiology of Werewolves, Proceed. Roy. Soc. Med., 57:23 (Jan.) 1964.

RESISTANCE TO HYPOXIA

Resistance to hypoxia has recently been reviewed.[3] This subject is not one of mere academic interest since diseases of the heart, circulation, blood and lungs may produce hypoxia. Most of the studies reported on hypoxia resistance have been concerned with determining the length of time small mammals can survive in an atmosphere of low oxygen tension. Valuable as such an approach is, it is not directly applicable to clinical situations.

It is known that the following are capable of producing an increased resistance to hypoxia: (a) changes in hydrogen-ion concentration in the blood produced, for example, by the administration of small amounts of carbon dioxide, by therapeutic doses of ammonium chloride, or by fasting; (b) physical factors such as hypothermia, or increased humidity; (c) ingestion of a carbohydrate diet; and (d) production of polycythemia.

Unfortunately there are not many practical methods which significantly increase resistance to clinical hypoxia. Only two will be discussed, namely the production of polycythemia, and the ingestion of a diet high in carbohydrates.

Producing polycythemia enables the blood to carry more oxygen to the tissues, thus increasing hypoxic resistance. There are a number of methods of producing polycythemia; among them are: transfusion of red blood cells, administration of cobalt chloride, breathing air containing small quantities of carbon monoxide, and sojourning at high altitudes. From the clinical standpoint, only two may be considered practical, namely, transfusion of red blood cells, and the administration of cobalt chloride.

Transfusion of blood is so well known that it need not be discussed here, except to state that if the patient has a normal red blood cell count, and the hemoglobin is within normal range, it is questionable whether injection of more red blood cells is justifiable.

The administration of therapeutic doses of cobalt chloride is a simple and inexpensive procedure. Unfortunately, unpleasant side effects may occur such as flushing of the skin, anorexia and even vomiting. Futhermore, there is some evidence the cobalt chloride may inhibit certain enzymes which are involved in oxygen utilization. It is thought also that cobalt chloride may induce thyroid hyperplasia and hypothyroidism on prolonged administration.

It was shown by Campbell[1] in 1938 that a carbohydrate diet produces hypoxic resistance in lower animals. This is not unexpected since the ingestion of carbohydrates elevates the Respiratory Quotient; more carbon dioxide is formed which in turn stimulates the respiratory center. The increased respiration augments pulmonary ventilation and the tissues receive more oxygen. Carbohydrates also furnish a good source of anaerobic energy.

Campbell[2] suggested a diet for patients suffering from oxygen want. In essence, this diet is high in carbohydrate but low in protein (5 per cent by dry weight) content. From theoretical considerations the hypoxia associated with certain clinical conditions should be alleviated by a diet rich in carbohydrates. It has as yet not been clearly proved, however, that such a diet is of distinct clinical aid.

In point of fact, in congestive heart failure, which is generally associated with a cardio-renal chain of events, considerable albumen is lost in the urine. Under such circumstances a diet rich in carbohydrates certainly would not be indicated. On the contrary, considerable protein should be allowed in the diet so that the normal colloid osmotic pressure of the plasma be maintained. Such proteins should preferably be low in sodium chloride, such as simple meats.

More research will have to be done before the armamentarium of the physician will contain an agent or procedure which will alleviate symptoms produced by hypoxia.

1. Campbell, J. A., Jr., J. Physiol., 93:31P, 1938.
2. Campbell, J. A., Jr., Quart. J. Exp. Physiol., 28:231, 1938
3. Van Liere, E. J., Arch. Int. Med., 113:418 (Mar.) 1964.

LO, THE POOR DOCTOR—HE CAN'T SAY 'NO'

Lawsuits against doctors are big news. When a doctor makes a wrong diagnosis that proves harmful to a patient, loud cries of protest are soon forthcoming from his other patients, from other doctors, and ultimately, from the patient's lawyer. The public loves to read about cases like this. Here is a big, successful guy "getting it" from a little guy. Here is a doctor—a man who makes a handsome living off people's sicknesses—being forced to the corner like a stag at bay. At last, it seems, a big power is at the mercy of an underdog.

In all the hullabaloo, the doctor's side seldom gets a fair public hearing. All most of us know is that the patient is a poor, suffering victim of some disease we don't understand, and that he was told to go home and take these little green pills when he should have been put in a hospital.

But the doctor has a strong case. Whenever a doctor makes a diagnosis, he faces problems that would give a chemist or physicist chronic insomnia. He has to weigh more facts than any other kind of scientist. Furthermore—and this is the hard part—he HAS to make a decision.

Other scientists can simply refuse to conclude anything from a given set of facts. They can plead that there are "too many uncontrolled variables." Or they can argue that there is "insufficient data on which to base a decision."

But not so the doctors. With them it's life or death. They can't beg off. To do so would be tantamount to a decision in itself—perhaps a fatal decision.

A chemist or physicist can limit the number of facts he has to consider in his experimental situation. Or if he can't, he doesn't have to do the research at all. But who ever heard of a doctor turning down a case because there were too many uncontrollable symptoms?

When a doctor makes a diagnosis, he has to consider the patient's age, sex, previous medical history, occupation, probable state of mind, what he had for breakfast, his personal habits, whether he is taking any medication, and so on. A given set of symptoms may indicate any of half a dozen conditions, depending on how the above facts shape up. Even after all the available facts have been weighed, several possible diagnoses may still present themselves—and a decision HAS to be made!

Let's say a doctor has diagnosed a condition—correctly—as diabetes. His troubles are still far from over. The same facts he had to consider in the diagnosis are there to plague him when he prescribes treatment. Diabetes in an elderly patient and diabetes in a young person are two very different conditions. The disease is one thing in a man, another in a woman. It's different if the patient also has other diseases—say tuberculosis. And there are at least two kinds of diabetes to start with—maybe more.

Scientifically, this is a mess. It would make even the best physicists throw up their hands and turn to more promising research. Yet doctors—who are usually expected to produce miracles—have to prescribe a course of treatment, using data that other scientists wouldn't consider suitable for a pilot study.

How far does a doctor's responsibility to a patient go, in the light of the enormously complex problems he faces? Understandably, there are a few doctors who feel their responsibility ends with being sure their patients can't sue them. But most go farther than this—sometimes at their peril. The legal dangers of "full responsibility" were pointed out very effectively last week by Dr. Scott N. Swisher of Rochester, N. Y., one of the speakers at the Pennsylvania Medical Society's annual meeting here.

Doctor Swisher noted that a physician who assumes full responsibility for his patient's condition also increases his own legal vulnerability. In making a diagnosis, for example, a doctor has a responsibility to use every available bit of scientific information he can bring to bear on a case; but very often, the most recent research findings are based on studies of large groups, and the results may not apply in individual cases. So, should the doctor use this information, or shouldn't he? If he does, he is taking a calculated risk.

Yet a doctor is expected to have a perfect record. He is expected to make deductions no other scientist would attempt, and if he makes a mistake the world never forgives him.

He does make mistakes, of course. That much is inevitable. But for the most part, they aren't readily apparent. It's the one mistake in 1,000, the one that costs a patient his comfort or his life, that brings down the public axe. And when the axe falls, it falls on the entire medical profession. *—Henry W. Pierce, Staff Writer, Pittsburgh Post-Gazette.*

If you've never seen a really, fully developed look of disgust, just tell your son how you conducted yourself when you were a boy.—Abe Martin.

GENERAL NEWS

Drs. Howard and Carter To Speak At 97th Annual Meeting

The Program Committee has announced that two distinguished physicians have been added to the list of guest speakers who will appear on the program at the 97th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 20-22.

Dr. William E. Gilmore of Parkersburg, the Chairman, said that Dr. John M. Howard of Philadelphia

Bayard Carter, M. D.

John M. Howard, M. D.

and Dr. Bayard Carter of Durham, North Carolina, have accepted invitations to present papers during the three-day meeting.

Doctor Howard, who is Professor of Surgery at Hahnemann Medical College in Philadelphia, will appear as a speaker at the first general session on Thursday morning, August 20.

Doctor Howard was born in Autaugaville, Alabama, and he received his M.D. degree in 1944 from the University of Pennsylvania School of Medicine. He interned and served a residency in surgery at the Hospital of the University of Pennsylvania, 1945-50.

Doctor Howard served as Director of the U.S. Army's Surgical Research Team in Korea, 1951-52, and he is the editor of several books and monograms on battle casualties in Korea. He is maintaining active research and clinical programs in the trauma and surgical fields.

He is certified by the American Board of Surgery and the American Board of Thoracic Surgery, and is a member of the American Medical Association, American College of Surgeons and the National Research Council.

Bayard Carter, M. D.

Dr. Bayard Carter, Professor of Obstetrics and Gynecology at the Duke University School of Medicine, also will appear as a speaker at the first general scientific session on Thursday morning, August 20.

He is a native of Wilmington, Delaware, and he received B.A. and M.A. degrees from the Honour School of Physiology, Oxford University, England, 1923-29.

He served as Head of the Department of Obstetrics and Gynecology at the University of Virginia School of Medicine, 1929-31, at which time he was named Head of the Department of Obstetrics and Gynecology at the Duke University School of Medicine.

He is certified by the American Board of Obstetrics and Gynecology and is a member of the American Association of Obstetricians and Gynecologists, American Gynecological Club and the Society of Pelvic Surgeons.

He is a member of the Southern Medical Association, American Medical Association, Southern Surgical, South Atlantic Association of Obstetricians and Gynecologists, American Gynecological Society and a Fellow of the American College of Obstetricians and Gynecologists.

Program Nearing Completion

The names of several other guest speakers were announced previously. They are:

Dr. Waldo E. Nelson of Philadelphia, Professor and Head of the Department of Pediatrics at the Temple University School of Medicine; and Dr. John C. Krantz of Baltimore, Professor and Head of the Department of Pharmacology at the University of Maryland School of Medicine. Drs. Nelson and Krantz will present papers at the second general session on Friday morning, August 21.

One of the honor guests at the meeting will be Dr. Perry E. Gresham, President of Bethany College. He will speak at the first general scientific session on Thursday morning, August 20.

Presidential Address

Dr. Charles L. Goodhand of Parkersburg, President of the State Medical Association, will deliver his Presidential Address at the second session of the House of Delegates on Saturday afternoon, August 22. The speaker at the first session of the House on Wednesday evening, August 19, will be Dr. Norman A. Welch of Boston, who will be installed as President of the American Medical Association in June.

Additional information concerning the program will appear in future issues of *The Journal*. The complete program will be published in the Convention Number in August.

Plans Completed for AMA Meeting In San Francisco, June 21-25

Plans have been completed for the 113th Annual Convention of the American Medical Association which will be held in San Francisco, June 21-25.

Dr. J. Arnold Bargen of Temple, Texas, Chairman of the AMA Council on Postgraduate Programs, said that the San Francisco program will be most comprehensive, including lectures, scientific exhibits, preview showings of medical films and color television.

The following general scientific sessions have been coordinated by section secretaries: differential diagnosis of the liver and pancreas, hyperbaric oxygen phenomona, computors in medicine, autoimmune mechanisms and disease, cardiovascular opacification, and tumors of the endocrine.

A special half-day program on various aspects of heart disease will be sponsored by the American College of Cardiology and the American Heart Association and the popular Research Forum program will be offered again at the San Francisco meeting.

Advance registration forms and information concerning hotel and motel accommodations may be found in each weekly issue of the *JAMA*. The scientific program will be published in the Convention Issue on May 9.

Dr. William L. Cooke Will Head National TB Association

Dr. William L. Cooke of Charleston will be installed as President of the National Tuberculosis Association during the 60th annual meeting which will be held at the Statler-Hilton Hotel in New York City, May 24-27.

The program for the American Thoracic Society, medical section of the Association, will feature 80 original scientific papers covering clinical and basic research in the field of respiratory diseases which will be presented at 13 sessions. The business meeting of the Society will be held on Tuesday, May 26.

Further information concerning the program may be obtained by writing the National Tuberculosis Association. 1790 Broadway, New York City 10019.

Medical Meetings, 1964

The following is a partial list of national, state and district medical meetings scheduled for 1964:

May 1-2—W. Va. Soc. Med. Technologists, Parkersburg.
May 6-8—Maryland Annual Meeting, Baltimore.
May 6-8—W. Va. PH Association, Charleston.
May 15-17—W. Va. Chapter, AAGP, Charleston.
June 18—B-R-T Postgraduate Session, Elkins
June 21-25—AMA Annual Meeting, San Francisco.
June 25—Preston Co. Summer Session, Kingwood.
Aug. 20-22—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 4—W. Va. Heart Assn., Huntington.
Oct. 1—Rural Health Conf., Jackson's Mill.
Oct. 23-25—Potomac-Shenandoah Valley PG Institute, Martinsburg.
Oct. 23-25—American Heart Assn., Atlantic City.
Nov. 16-19—Southern Medical, Memphis, Tenn.
Nov. 29-Dec. 2—AMA Clinical Meeting, Miami Beach.

Norman A. Welch, M. D.

Dr. Norman A. Welch Honor Guest At 97th Annual Meeting

The Program Committee has announced that Dr. Norman A. Welch of Boston, who will be installed as President of the American Medical Association at the annual convention in San Francisco in June, will be an honor guest at the 97th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 20-22.

Dr. William E. Gilmore of Parkersburg, the Chairman, said that Doctor Welch will be the guest speaker before the first session of the House of Delegates on Wednesday evening, August 19, the day preceding the formal opening of the meeting.

Doctor Welch was born in Brockton, Massachusetts, and was graduated in 1926 from Tufts University School of Medicine. He interned and served a residency at the Carney Hospital in Boston, and served as an Instructor in Medicine at Boston University School of Medicine, 1933-43. From 1943-57, he was Clinical Professor of Medicine at Tufts University School of Medicine and Physician-in-Chief at Carney Hospital.

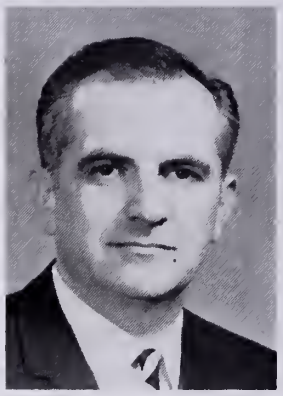
Doctor Welch was President of the Massachusetts Medical Service (Blue Shield) from 1950-63, and Chairman of the National Blue Shield Commission, 1955-58.

He is a past president of the Council of the New England State Medical Societies and was elected a member of the AMA House of Delegates in 1951. He served as Speaker of the House for four years, 1959-63, and was named president elect during the annual meeting in Atlantic City last June.

12th Annual GP Scientific Assembly In Charleston, May 15-17

Eighteen physicians and surgeons have accepted invitations to appear as guest speakers at the 12th Annual Scientific Assembly of the West Virginia Chapter of the American Academy of General Practice, which will be held at the Civic Center in Charleston, May 15-17.

Dr. Peter A. Haley of Charleston, general chairman of the convention, said that more than 200 physicians are expected to attend the three-day meeting. General scientific sessions will be held mornings and afternoons on Saturday and Sunday, in addition to an afternoon session on Friday, May 15.



Beverley T. Mead, M. D.

T. L. Montgomery, M. D.

Thoracic Society Program

Dr. Joseph A. Smith of Dunbar, the president, will call the meeting to order at 1:30 p.m. on Friday, May 15. The invocation will be given by the Rev. Alfred E. Bennett of Charleston and addresses of welcome by Mayor John A. Shanklin of Charleston; Dr. Charles L. Goodhand, President of the West Virginia State Medical Association; and Dr. George L. Grubb of Charleston, President of the Kanawha Medical Society.

Dr. Donald P. Brown of Kingwood, Chairman of the Program Committee, has announced that the scientific session that afternoon will be devoted to a program sponsored by the West Virginia Thoracic Society, the medical advisory section of the West Virginia Tuberculosis and Health Association. Dr. William L. Cooke of Charleston, President of the National Tuberculosis Association, will preside and serve as moderator of a panel discussion following presentation of papers.

The speakers and their subjects are as follows:

1:45—"Emphysema."—John P. Wyatt, M. D., Professor and Director, Department of Pathology, St. Louis University School of Medicine, St. Louis, Missouri.

2:30—"Coal Workers Pneumoconiosis."—Donald L. Rasmussen, M. D., Chief, Appalachian Coal Miners Research Unit, U. S. Public Health Service, Beckley Memorial Hospital, Beckley.

3:45—"Silicosis."—Charles E. Andrews, M. D., Professor of Medicine, West Virginia University School of Medicine.

4:30—Panel Discussion.

Saturday Morning, May 16

9:00—"Current Therapy in Thyroid Disease."—George Crile, Jr., Head of Department of General Surgery, The Cleveland Clinic.

9:30—"Renal Vascular Occlusive Disease and Renal Transplantation."—Charles C. Wolferth, Jr., M. D., Associate Professor of Surgery, Hahnemann Medical College and Hospital, Philadelphia.

10:30—"What Are We to Think and Do About Cancer of the Breast: An Obstetrician and Gynecologist Views the Problem of Diagnosis and Treatment."—Thaddeus L. Montgomery, M. D., Professor Emeritus of Obstetrics and Gynecology, Jefferson Medical College, Philadelphia.

11.00—"Undescended Testicles."—William B. Kiesewetter, M. D., Professor of Pediatric Surgery, University of Pittsburgh School of Medicine.

11:30—Panel Discussion.

Saturday Afternoon

1:30—"Environmental Effects on the Fetus."—D. Frank Kaltreider, M. D., Professor of Obstetrics and Gynecology, University of Maryland School of Medicine.

2:00—"Prolonged Labor."—James G. Sites, M. D., Assistant Professor of Obstetrics and Gynecology, George Washington University School of Medicine, Washington, D. C.

2:30—"An Evaluation of the Newer Penicillins in Infants and Children."—Sydney Ross, M. D., Associate Professor, Georgetown University School of Medicine, Washington, D. C.

3:30—"Most Recent Advances in Immunization of Children Against Communicable Diseases."—James L. Goddard, M. D., Chief, Communicable Disease Center, Bureau of State Services, Atlanta, Georgia.

4:30—Panel Discussion.

D. Frank Kaltreider, M. D.

John P. Wyatt, M. D.

Sunday Program

9:00—"Family Physician Psychotherapy."—Beverley T. Mead, Director, Continuing Education Program in Psychiatry, University of Kentucky College of Medicine; Lexington, Kentucky.

9:30—"Convulsive Disorders in Children With a Consideration of the Extent of Diagnostic Studies and Drug Therapy."—Richard S. Paine, M. D., Professor of Pediatric Neurology, George Washington University School of Medicine, Washington, D. C.

10:00—"Obesity: What Can or Cannot be Done With the Obese Child or Adolescent."—Felix P. Heald, Jr., M. D., Associate Professor of Pediatrics, Georgetown University School of Medicine, Washington, D. C.

11:00—"The Prevention of Recurrences of Myocardial Infarction."—Benjamin Manchester, M. D., Associate Clinical Professor of Medicine, George Washington University School of Medicine, Washington, D. C.

12:00—"Atherosclerosis: Biochemistry and Treatment."—Sheldon R. Bender, M. D., Assistant Professor of Medicine, Section on Cardiovascular Disease, Hahnemann Medical College and Hospital, Philadelphia.

12:30—Panel Discussion.

Moderators of Panel Discussions

The following members of the Academy will serve as moderators of panel discussions which will follow the presentation of papers at each general session: Dr. J. C. Huffman of Buckhannon, Dr. Myer Bogarad of Weirton and Dr. Seigle W. Parks of Fairmont.

12 Hours of Category 1 Credit

Dr. Donald P. Brown, Chairman of the Program Committee, said that members of the American Academy of General Practice will be granted 12 Hours of Category 1 Credit for attendance at the three-day meeting.

Doctor Haley To Be Installed as President

Dr. Peter A. Haley of Charleston, the president elect, will be installed as president during the meeting, succeeding Dr. Joseph A. Smith of Dunbar.

Other officers are Dr. Jack Leckie of Huntington, vice president; Dr. L. Dale Simmons of Clarksburg, secretary; and Dr. Martha J. Coyner of Harrisville, treasurer. Dr. Joseph A. Smith of Dunbar is chairman of the Board of Directors, and Dr. Seigle W. Parks of Fairmont, Editor of *Mister Doc*, official publication of the Chapter.

Pre-Convention Meetings

A meeting of the Board of Directors will be held at the Holiday Inn on Thursday evening, May 14. The House of Delegates will be convened at the Civic Center at 10 o'clock on Friday morning, May 15, and the official order of business will include an address by the President, Dr. Joseph A. Smith. The election of officers for the coming year also will be held at that time.

Dr. John W. Hash of Charleston will serve as toastmaster at a banquet which will be held at the Sterling Restaurant Banquet Room on Saturday evening, May 16. A social hour will precede the banquet.

The invocation will be given by Dr. Carl B. Hall of Charleston and the members and guests will be welcomed by Doctor Smith.

Mrs. William D. Crigger of South Charleston will serve as chairman of the entertainment committee for the wives of visiting physicians. Other members of the committee are Mrs. Peter A. Haley, Mrs. Marshall J. Carper and Dr. Jean Cavender of Charleston and Mrs. Edward Jackson of St. Albans.

The Charleston Light Opera Guild will present "Kismet" at the Civic Center Little Theatre at 8:30 P.M. on Friday night.

Dr. James L. Cunningham Nearing 101 And Still Going Strong

Dr. James L. Cunningham of Pickens, West Virginia's oldest physician, is nearing 101 and still going strong.

Several friends gathered at his home on March 30 to honor him on Doctor's Day. Miss Shirley Hoener of Quincy, Illinois, pinned a red carnation on his lapel.

A Carnation for Doctor Cunningham

Miss Hoener, a second-year student at the West Virginia University School of Nursing, was visiting at the home of Dr. and Mrs. Harold D. Almond in Buckhannon. She is a cousin of Mrs. Almond.

Doctor Cunningham was born on September 1, 1863, just two months after West Virginia became a State on June 20, 1863. He was the family doctor for the Pickens-Helvetia-Hacker's Valley area from 1891 until his retirement several years ago.

He delivered 3,600 babies and never lost a mother. His "children" are to be found in every state of the Union except in the upper New England area.

"You big city physicians have it easy," he once told another doctor who asked about his practice high in the West Virginia hills. "If you have a problem you call up the oldest and smartest doctor in town and say to him, 'What would you do if you had such and such a case?' and he tells you the answer.

"It's different with me. I am the oldest and smartest and the dumbest and the only doctor in Pickens; so I have to ask myself for all of the answers, and I have been for 64 years of practice."

After receiving the carnation from Miss Hoener, Doctor Cunningham recounted some of his experiences and with a twinkle in his eye, picked up a property tax statement which he had received recently.

"You never grow so good or so old," he smiled, "that you still don't have to pay taxes."

Dr. Charles L. Goodhand of Parkersburg, left, President of the West Virginia State Medical Association, presents a check for $11,607.91 from the American Medical Association Education and Research Fund to Dean Clark K. Sleeth of the West Virginia University School of Medicine. Doctor Goodhand made the presentation during a ceremony held at the WVU Medical Center in Morgantown on April 7. The grant is part of $1,208,463 contributed throughout the country by physicians, their families and friends to the AMA-ERF.

PG Course in Washington

The American College of Physicians will sponsor a five-day postgraduate course on "Clinical Auscultation of the Heart" at the Georgetown University Medical Center in Washington, D. C., May 11-15.

The course will center around the presentation of a large number of patients who demonstrate the normal as well as the abnormal findings of clinical auscultation of the heart.

The registration fee will be $60 for ACP members and $100 for non-members. Further information may be obtained by writing Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pennsylvania 19104.

PG Course on Care of Adolescent Planned in Boston, May 25-29

A postgraduate course on "The Medical Care of the Adolescent" will be presented by the American College of Physicians at the Jimmy Fund Building in Boston, May 25-29.

The intensive course of instruction, under the direction of Dr. Roswell Gallagher, is designed to cover the diagnosis and treatment of many disorders common in adolescence, as well as various aspects of the understanding and evaluation of boys and girls who are between 12 and 21 years of age.

Among the subjects to be covered are obesity, menstrual problems, management of the adolescent's office visit, skin problems, physiological and psychological characteristics of adolescence, school failure, cardiac, gastrointestinal and endocrine disorders, scoliosis, athletic injuries and other orthopedic problems, and the treatment of everyday personality and emotional difficulties.

The registration fee is $60 for ACP members and $100 for non-members. Further information may be obtained by writing to Dr. Edward C. Rosenow, Jr., Executive Director, 4200 Pine Street, Philadelphia, Pennsylvania 19104.

Ob. and Gyn. Applications Due July 1

The American Board of Obstetrics and Gynecology has announced that the final date for the receipt of applications, letters requesting reopening of applications, or reexamination, is July 1, 1964.

All applications and letters of request must be accompanied by duplicate lists of patient dismissals for the twelve months immediately preceding application.

Further information may be obtained by writing the Secretary, Dr. Clyde L. Randall, 100 Meadow Road, Buffalo 16, New York.

About 40 clergymen and physicians attended an afternoon seminar on Medicine and Religion which was held at the Holiday Inn in Charleston on April 11. Mr. Arne E. Larson of Chicago, Assistant Director of the AMA Department of Medicine and Religion, was the guest speaker. A panel discussion was led by, left to right, Dr. Marshall J. Carper of Charleston, Rev. V. B. McGehee of St. Albans, Mr. Larson, Dr. Tracy N. Spencer, Jr., of South Charleston, and Rev. Edward C. Elliott of Charleston.

Public Health Association Meeting In Charleston, May 6-8

The 40th Annual Meeting of the West Virginia Public Health Association will be held at the Daniel Boone Hotel in Charleston, May 6-8.

The theme for the meeting, "Health Problems—Southern Appalachia," will be studied during the first general session on Thursday morning, May 7. Dr. Emil E. Palmquist, Regional Health Director of the Public Health Service, will serve as moderator and the participants will be the following State Directors of Health: Dr. N. H. Dyer of West Virginia, Dr. Mack I. Shanholtz of Virginia and Dr. Russell E. Teague of Kentucky.

The second general session on Friday morning, May 8, will feature a U. S. Public Health Service Seminar on Immunizations. Among those participating in the program from the Chronic Disease Center in Atlanta, Georgia, will be Dr. Donald S. Martin, Chief of the Training Center; Dr. Warren A. Rasmussen, Chief of State Aids Section; and Dr. Walter Sheffel, Training Specialist. Doctor Dyer and other personnel from the State and local health departments also will participate.

Nearly 500 public health specialists from federal and state health units, voluntary health organizations and community groups are expected to attend the two-day conference.

William H. Lively, the president, will preside at the annual membership business meeting which will be held at the conclusion of the first general session on Thursday morning. The president elect of the organization is Mr. James E. Rosencrance, Sanitary Chemist with the State Department of Health.

A dinner meeting of the Executive Council will be held on Wednesday evening, May 6, and section meetings will be held on Thursday and Friday afternoons.

Doctor Dyer will serve as master of ceremonies at the banquet on Friday evening, and the speaker will be Senator Robert C. Byrd.

Mack I. Shanholtz, M. D.

Russell E. Teague, M. D.

Preston County Summer Meeting In Kingwood on June 25

The annual recreational and scientific meeting of the Preston County Medical Society will be held at the Preston Country Club near Kingwood on Thursday, June 25.

Dr. Theodore Kamholtz, who practices radiology in Brooklyn, New York, will be the speaker at the banquet which will be held in connection with the one-day meeting. Doctor Kamholtz writes satire for magazines and has had 46 articles published, 15 in the *JAMA*.

The golf tournament will begin at 8:30 A. M. and close at 5:00 P. M., and the trapshooting tournament will be held between 11:00 A. M. and 4:00 P. M. Prizes will be awarded to winners at the banquet, which will be preceded by a social hour.

Physicians throughout the State have been issued a cordial invitation to attend the meeting. Physicians planning to attend should contact Dr. C. Y. Moser of Kingwood, Secretary of the Preston County Medical Society.

Dr. Norman A. Welch of Boston, second from right, is shown with three Wheeling physicians during a recent visit to that city. They are, left to right, Dr. George M. Kellas and Dr. M. B. Williams, medical directors at Wheeling and Ohio Valley General Hospitals, and Dr. Joseph L. Curry, president of the Ohio County Medical Society. (Photo Courtesy of the Wheeling News-Register).

Symposium on Pediatrics Planned In Morgantown, May 14-15

The West Virginia Pediatric Society and the West Virginia Chapter of the American Academy of Pediatrics will sponsor a Symposium on "The Pediatric Frontier" at the West Virginia University Medical Center in Morgantown, May 14-15.

Dr. Russell V. Lucas, Jr., Assistant Professor of Pediatrics and Chairman of the Program Committee, announced that three out-of-state physicians and eight members of the WVU School of Medicine faculty have accepted invitations to participate in the two-day meeting.

The first scientific session on Thursday afternoon, May 14, will be devoted to viruses. The speakers and their subjects are as follows:

"The Fundamental Nature of Viruses."—Carmine C. Mascoli, Ph. D., Associate Professor of Microbiology, WVU School of Medicine.

"Viral Infections in Children."—Robert H. Parrott, M. D., Medical Director, Children's Hospital, Washington, D. C.

"Viral Vaccines: Present and Future."—Robert Burrell, Ph.D., Assistant Professor of Microbiology, WVU School of Medicine.

Dr. W. Gene Klingberg, Professor and Chairman of Pediatrics at the WVU School of Medicine, will moderate a panel discusion on "What's in the Virologists' Crystal Ball?"

The Friday morning scientific session will be devoted to "Inborn Errors of Metabolism."

Dr. Reginald F. Krause, Professor and Chairman of Biochemistry at the WVU School of Medicine, and Doctor Klingberg will discuss the basic biochemistry and clinical aspects of "Inborn Errors of Carbohydrate Metabolism" in the first segment.

Dr. James B. Gilbert, Assistant Professor of Biochemistry at the WVU School of Medicine, and Dr. Thomas J. Egan, Director of the Clinical Study Center of Children's Hospital in Pittsburgh, will discuss "Inborn Errors of Amino Acid Metabolism" in the second portion of the morning program.

Dr. Gerald D. LaVeck, Director of the Mental Retardation Program at the National Institute of Child Health and Human Development in Bethesda, Maryland, will present a paper on "Medical Advances in Prevention of Mental Retardation" to open the Friday afternoon session.

Round table discussions at 2:45 and 4:15 P. M. will conclude the program. Subjects to be discussed will include "Common Electrolyte Problems," "Practice Problems in the Care of Retarded Children," "Use and Abuse of Antibiotics," "Diagnosis and Treatment of Anemia," "Approach to Clinical Allergy," and "Diagnosis of Innocent Heart Murmurs in Children."

The discussion leaders will be Drs. Egan, LaVeck, Parrott, Lucas, Barbara Jones and Robert J. Nottingham. Doctor Jones is an Associate Professor and Doctor Nottingham an Assistant Professor of Pediatrics at the WVU School of Medicine.

Robert H. Parrott, M. D.

Gerald D. LaVeck, M. D.

Further information may be obtained by writing to Dr. Russell V. Lucas, Jr., Department of Pediatrics, West Virginia University Medical Center, Morgantown.

Annual B-R-T Postgraduate Session In Elkins on June 18

The Annual Postgraduate Meeting of the Barbour-Randolph-Tucker County Medical Society will be held at the Elks Country Club near Elkins on Thursday, June 18.

Dr. Paul D. Snedegar of Elkins, Chairman of the Program Committee, announced that the scientific session will begin at 2:00 P. M.

Dr. Charles L. Leonard of Elkins will serve as the moderator for a "Symposium on Alcoholism," and the speakers and their subjects will be as follows:

2:00—"Toxic Effects of Alcohol on the Human Body."—David W. Northup, Ph. D., Professor of Pharmacology, West Virginia University School of Medicine.

2:30—"The Personality and Behavior of the Alcoholic."—William Jones Browne, M. D.. Psychiatrist, Staunton Clinic, Pittsburgh.

3:00—"The Family Physician and His Alcoholic Patient."—Joseph Chambers, M. D., Physician-in-Charge, Alcoholic Unit, District of Columbia General Hospital, Washington.

4:00—"The Medical Profession and Alcoholics Anonymous."—W. T. Dixon Gibbs, Executive Director, Baltimore Area Council on Alcoholism, Baltimore.

4:30—Panel Discussion on Alcoholism.

A golf tournament will be held in connection with the one-day meeting. The co-chairmen of the tournament, Drs. Herman Seltz of Elkins and Homer D. Martin of Dailey, have requested that golfers register at the caddy house at 9:00 A. M.

Dr. Arch C. Thompson will serve as toastmaster at a banquet which will be held at 6:30 P. M. The entertainment feature will be dinner music of yesteryear by Lillian Henry and Alex Goldberg.

The speaker at the banquet will be Alex Klieforth, Program Director of the Voice of America.

Physicians throughout West Virginia have been extended a cordial invitation to attend the meeting.

Physicians, Poison Control Centers Praised by Health Department

West Virginia physicians and poison control centers have been commended by the State Department of Health for keeping deaths from accidental poisonings to a minimum in West Virginia last year.

In his weekly State of the State's Health, State Director of Health Dr. N. H. Dyer said that through the conscientious efforts of physicians and the informational services of West Virginia's 14 control centers, only 52 accidental poisoning deaths occurred in 1963.

More than a million persons are accidentally poisoned in the United States annually, making the problem harassing and a serious public health threat. The health director said the team of the poison center and private physician in West Virginia can be applauded for a job well done.

Unfortunately, however, many of the 900 West Virginia children who accidentally ingest household bleach, aspirin, liniment, rubbing alcohol, disinfectants, furniture polish, bluing and ammonia, hair dye, skin lotions and insecticides each year and survive must go through life permanently handicapped from damage to the digestive system, liver and kidneys.

The poison control centers maintain records of tradename products, ingredients, toxicity and treatment, and information is available to physicians by telephone day or night. Many of the centers are located in hospitals. Some provide information only and others offer emergency treatment—but, their primary purpose is to provide information to the private physician.

The West Virginia poison control centers are located at Beckley Hospital, Beckley; E. I. duPont deNemours & Company, Belle; Charleston General Hospital, Charleston; Charleston Memorial Hospital, Charleston; St. Mary's Hospital, Clarksburg; Cabell-Huntington Hospital, Huntington; St. Mary's Hospital, Huntington; West Virginia University Hospital, Morgantown; Camden-Clark Hospital, Parkersburg; St. Joseph's Hospital, Parkersburg; Pine Drug Store, Pine Grove; Greenbrier Valley Hospital, Ronceverte; Stonewall Jackson Hospital, Weston; and Weirton General Hospital, Weirton.

Record Levels in Births, Deaths

More strong evidence that West Virginia is losing its younger population was disclosed recently in provisional figures released by the Division of Vital Statistics. They recorded high and low levels in West Virginia deaths and births in 1963. Births were the lowest since 1921 and deaths the highest since inception of the Division in 1917.

The report said deaths in the State increased over 1,000 from 1962 figures to 19,735. By the same token, births in the state dwindled nearly 1,000 under 1962 totals, with 36,346 live births. The reduction in births is related to the continued out-migration of West Virginia's younger population—in this case those of the childbearing ages.

Four West Virginians attended the recent Congress on Medicine and Pharmacy in Chicago. Dr. L. Dale Simmons of Clarksburg, left, Chairman of the Committee on Medico-Pharmaceutical Relations, and Dr. Charles L. Goodhand of Parkersburg, the President, represented the State Medical Association. They are shown with Mr. J. W. Pugh of Martinsburg and Mr. William J. Dixon of Oak Hill, President and Secretary-Manager, respectively, of the State Pharmaceutical Association.

Veterans Administration Expanding Program of Research in Aging

Dr. George M. Lyon, Director of the Huntington VA Hospital, anounced recently that the Veterans Administration is expanding its program of research in aging. He said major emphasis is being placed upon new ideas and new approaches to the many problems which aging and the increasing population of senior citizens presents.

To accomplish this, the VA is attempting to obtain the cooperation of non-VA scientists and physicians, not those necessarily identified with the aging field, but those known to have important ideas on the subject.

These persons are being offered facilities and staff in nearby VA hospitals as "satellite laboratories" in which the VA will serve as a partner in advancing their ideas. Doctor Lyon said the first such laboratory has been established at the Bedford, Massachusetts, VA Hospital in partnership with Drs. Robert Herman and Marott Sinex of the Department of Biochemistry at the Boston University School of Medicine.

Consultants and attending physicians at the Huntington VA Hospital participate actively with full-time staff members in the medical research program which is closely related to the problems of the older patient. Among these are Drs. Siegfried Werthammer, M. Lawrence White, Jr., and James P. Carey and John H. Hoback, Ph. D., of Marshall University.

Doctor Lyon said the VA's nationwide system of 168 hospitals uniquely lends itself to such an approach. Such research is made all the more feasible by the fact that many VA hospitals already are intimately affiliated with schools of medicine for research and educational purposes.

Dr. Merle S. Scherr of Charleston, left, secretary-treasurer of the West Virginia State Society of Allergy, presents an honorary membership to Dr. Pierre Brenot of Angers, France. Doctor Brenot visited Charleston with a group of French Rotarians. Dr. Jacques Charbonnier, right, a resident at Charleston General Hospital, served as interpreter.

16 Physicians Attend Travel Meeting Of W. Va. Ob.-Gyn. Society

Sixteen physicians attended the Annual Travel Meeting of the West Virginia Obstetrical and Gynecological Society which was held at the West Virginia University Medical Center in Morgantown, March 19-21.

Dr. Clark K. Sleeth, Dean of the WVU School of Medicine, gave the address of welcome and Dr. Nicholas W. Fugo, Professor and Chairman of Obstetrics and Gynecology, was the program chairman.

Doctor Fugo, Dr. Robert Greco and Dr. Dean R. Goplerud served as moderators for the three scientific sessions. Doctor Greco is Clinical Assistant Professor and Doctor Goplerud an Instructor in Obstetrics and Gynecology.

Fourteen papers were presented by members of the WVU School of Medicine faculty. In addition to Drs. Fugo, Greco and Goplerud, others presenting papers were Drs. E. W. Chick, W. Gene Klingberg, Barbara Jones, Robert J. Nottingham, Bernard Zimmermann, N. W. B. Craythorne, Herbert E. Warden, Russell V. Lucas, Jr., Victor M. Napoli and George G. Green.

A banquet was held at the Lakeview Country Club on Friday evening, March 20, for the attending physicians and faculty and their wives.

Medical Seminar in Hawaii

The Second Hawaii Medical Seminar will be held in Honolulu, June 26-July 1, immediately following the Annual Meeting of the American Medical Association in San Francisco.

The Seminar will be sponsored by the Hawaii Medical Association and will feature speakers both from the mainland and Hawaii. Scientific sessions will be interspersed with an attractive program of entertainment and hospitality events.

Complete details concerning transportation and hotel arrangements may be obtained by writing the Hawaii Medical Seminar, Suite 300, 1612 K Street, Washington, D. C. 20006.

New Association Members

Dr. Camilla R. Bauer, RFD No. 4, Box 155, Wheeling (Ohio). Doctor Bauer, a native of Patton, Pennsylvania, was graduated from Seton Hall College and received her M.D. degree in 1953 from the Woman's Medical College of Pennsylvania. She interned at Conemaugh Valley Memorial Hospital in Johnstown, 1953-54, and served a residency at Baylor University College of Medicine in Houston, 1958-62. Her specialty is radiology.

* * * *

Dr. Charles R. Chamberlain, Jr., WVU Medical Center, Morgantown (Monongalia). Doctor Chamberlain was born in Altoona, Pennsylvania, and was graduated from Virginia Military Institute. He received his M.D. degree in 1957 from the University of Virginia School of Medicine. He interned at Johns Hopkins Hospital in Baltimore, 1957-58, and served a residency at the University of Virginia Hospital in Charlottesville, 1958-61. He is certified by the American Board of Pathology and is currently serving as Assistant Professor of Pathology at the WVU School of Medicine.

* * * *

Dr. Frederick M. Cooley, 4008-B MacCorkle Avenue, S. E. Charleston (Kanawha). Doctor Cooley, a native of Charleston, was graduated from West Virginia University and received his M.D. degree in 1962 from the West Virginia University School of Medicine. He interned at Charleston Memorial Hospital, 1962-63. He served with the United States Air Force, 1951-52, and he is engaged in general practice.

* * * *

Dr. Fernando G. Giustini, Peoples Federal Building, Wheeling (Ohio). Doctor Giustini, a native of Italy, attended Duquesne University and received his M.D. degree in 1956 from the University of Rome. He interned at Wheeling Hospital, 1956-57, and served a residency at the E. S. Magee Hospital in Pittsburgh, 1957-60. He served as a Captain in the Medical Corps of the United States Air Force and was stationed at the Westover Air Force Base in Massachusetts. His specialty is obstetrics and gynecology.

* * * *

Dr. Dennis S. O'Connor, St. Mary's Hospital, Huntington (Cabell). Doctor O'Connor, a native of Philadelphia, was graduated from LaSalle College and received his M. D. degree in 1954 from Jefferson Medical College. He interned at Misericordia Hospital in Philadelphia, 1954-55, and served a residency at Jefferson Medical College Hospital, 1958-61. He served as a Lieutenant in the Medical Corps of the United States Navy, 1955-57, and his specialty is pathology.

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Dr. Patrick C. Williams, Jr., 1215 Quarrier Street, Charleston (Kanawha). Doctor Williams, a native of Wevaco, Kanawha County, attended the two-year WVU School of Medicine and received his M.D. degree in 1958 from the Medical College of Virginia. He interned at Charleston Memorial Hospital, 1958-59, and served a residency at that hospital and at the Huron Road Hospital in Cleveland, 1959-63. His specialty is obstetrics and gynecology.

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Survey of Snakebites in West Virginia*†

Henry M. Parrish, M. D., Dr. P. H.

West Virginia has the third highest annual snakebite rate of the states east of the Mississippi River. The leading annual snakebite rates per 100,000 population for these states are found in North Carolina (18.79), Georgia (13.44), West Virginia (11.29), Mississippi (10.83) and South Carolina (7.72). Thus poisonous snakebites are a problem of considerable magnitude in the southeastern states.

It is surprising that only one person in West Virginia died from a poisonous snakebite during the ten year period, 1950-1959.[1] Very little has been written about West Virginia's snakebite problem. Therefore, it seemed worthwhile to make a statewide survey for the following purposes: (1) to define the epidemiology of poisonous snakebites in West Virginia; (2) to relate some medical findings associated with these bites; and (3) to review briefly current concepts of snakebite treatment.

Poisonous Snakes

According to Conant,[2] there are two species of poisonous snakes that are indigenous to West Virginia: the timber rattlesnake (*Crotalus horridus horridus*) and the northern copperhead (*Agkistrodon contortrix mokeson*). See Figure 1 for photographs of poisonous snakes of West Virginia. Both of these snakes are pit vipers. They are so named because of a characteristic pit which is located between the eye and nostril on each side of the body. Pit vipers also are identified by elliptical pupils and by two well-developed fangs which protrude from the maxillae when the snake's mouth is opened. Rattlesnakes have rattles which are attached to their tails. Copperheads and harmless snakes do not have rattles. Harmless snakes do not have facial pits, they have round rather than elliptical pupils, and while they have teeth, they lack fangs.

Oftentimes people will chop off the head of a snake which has bitten someone and bring the snake's body in for identification. Pit vipers can be identified by turning the snake's belly upwards and noting a single row of subcaudal plates just below the anal plate. Harmless snakes have a double row of subcaudal plates. Figure 2 depicts the characteristic features of pit vipers and harmless snakes.

Methods of Study

A questionnaire and letter explaining the purpose of this study were mailed to a "selected" group of West Virginia hospitals listed in Hospitals (*Journal of the American Hospital Association*) Guide Issue. The hospitals selected for this study were general hospitals, children's hospitals and college infirmaries. Army, Navy, Coast Guard, Public Health Service, Air Force and Veterans Administration hospitals also were sent questionnaires. Maternity, tuberculosis and mental hospitals were omitted as they would not be expected to treat snakebite victims. A total of 72 West Virginia hospitals comprise the study group. Each hospital was requested to report all in-patients admitted to the hospital for snakebite treatment during 1958 and 1959.

The Author

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***From the Department of Community Health and Medical Practice, University of Missouri School of Medicine, Columbia, Missouri.**

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Submitted to the Publication Committee, March 6, 1964.

Most hospitals do not code and tabulate the diagnoses of emergency room and out-patient clinic visits. Since some snakebite victims are not admitted to the hospital as in-patients, it seemed essential to ask a sample of practicing physicians how many snakebite victims they treated on both an out-patient (office, home, emergency room, etc.) and on an in-patient basis. Previous surveys[3,4] have shown that most people with venomous snakebites are treated by general practitioners, surgeons, internists, pediatricians and orthopedic surgeons. Therefore, a random sample of one-third of all the West Virginia physicians in these categories of practice who were listed in the American Medical Directory were sent questionnaires.

Death certificates for fatal snakebite cases were obtained from the West Virginia State Department of Health.

Results

This report is based on questionnaires returned by 62 (86 per cent) of 72 West Virginia hospitals. It is supplemented by questionnaires returned by 206 (73 per cent) of 281 practicing physicians in the State. The West Virginia State Department of Health indicated that there was one snakebite death during 1958 and none during 1959.

Incidence.—West Virginia hospitals reported a total of 141 in-patients treated for poisonous snakebites during 1958 and 1959. There were 67 cases in 1958 and 74 cases in 1959—an average of 70.5 cases per year. Of the 141 snakebites reported during 1958 and 1959, detailed case reports were received for 104 patients and only numbers of bites were reported for 37 cases. *All of the analyses in this paper, excluding the estimate of incidence, were based on the 104 detailed case reports received from hospitals.*

Physicians' reports, when adjusted to account for all West Virginia physicians in the practice categories mentioned, indicated that approximately 111 in-patients and 99 out-patients were treated for snakebite accidents each year. The difference between the estimate of 111 in-patients treated by physicians and the average of 70 in-patients reported by hospitals can be explained, in part, by the following facts: (1) ten (14 per cent) of the West Virginia hospitals did not participate in the study; (2) eight counties from which physicians reported snakebites did not have hospitals listed in the Hospitals Guide Issue; (3) there was evidence of under reporting snakebite in-patients from five hospitals which participated in the study; and (4) physicians indicated that many in-patients were treated in small clinics and hospitals not listed in Hospitals Guide Issue. Taking all of these various reports into consideration, I estimate that approximately 210 (111 in-patients and 99 out-patients) people are treated annually for poisonous snakebites in West Virginia. This provides an incidence of 11.29 bites per 100,000 population per year.

Geopathology.—The geographical distribution of snakebites reported in West Virginia during 1958 and 1959 may be seen in Figure 3. The lightly shaded counties are those from which hospitals reported in-patients treated for snakebites. An appropriate symbol is used to mark each hospitalized patient who was bitten by a specific kind of snake. The darker shaded counties are those counties from which physicians reported snakebite cases, but from which no cases were reported by hospitals.

Of 104 people hospitalized for snakebite treatment for whom detailed records were available, 72 (69 per cent) were bitten by copperheads,

Figure 1. Venomous Snakes Indigenous to West Virginia.

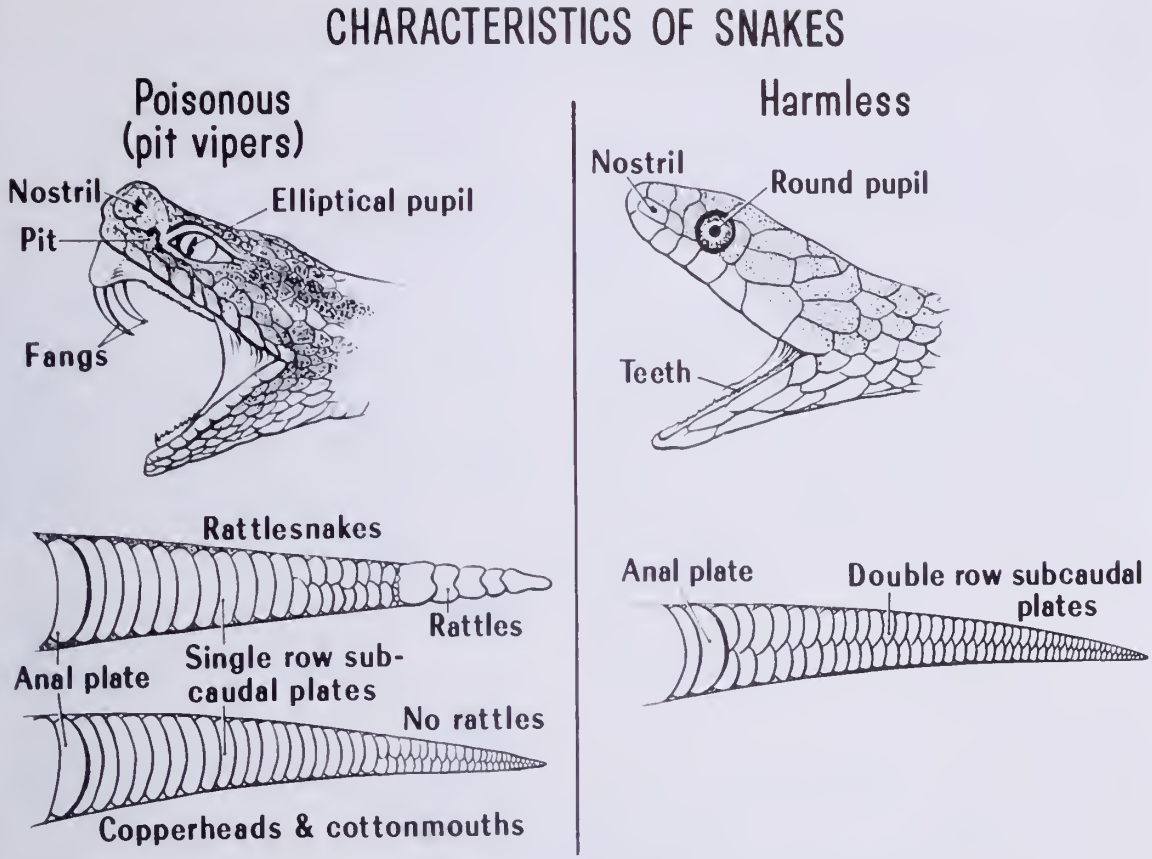

Figure 2. Characteristic Features of Poisonous Snakes (Pit Vipers) and Harmless Snakes.

5 (5 per cent) by rattlesnakes, and 27 (26 per cent) by unidentified poisonous snakes.

Figure 3 shows snakebites were reported from all sections of the State. Copperhead bites occurred in all sections of the State, but were most frequent in the southcentral and southwestern parts of West Virginia. Likewise, most rattlesnake bites were in the southcentral and southwestern parts of the State. The geographical patterns of bites by these snakes are consistent with the ecological ranges of poisonous snakes in West Virginia described by Conant.[2] According to him, copperheads and timber ratlesnakes are found throughout the State.

Temporal Relationships.—The monthly distribution of snakebite accidents is shown in Table 1. There were no snakebites during the colder months of the year—November, December, January, February and March. In general, snakes are usually inactive and/or hibernating during the colder months. Most snakebites in West Virginia occurred from May through October when 103 (99 per cent) of the 104 bites were inflicted. This striking seasonal distribution of bites coincides with the time that snakes are most abundant and active and with the time that people have greater exposure due to out-of-doors occupations and recreation. Similar "seasonal epidemics" of venomous snakebites have been observed in New England and Florida.[3,4]

The time of day when most snakebite accidents happened was the nine hour period from 12:00 noon-8:59 P.M. when 62 (70 per cent) people were bitten. This 70 per cent is derived from the 89 cases in which the time of the bite accident was reported. For 15 cases the time was not stated. The number of bites by three hour periods of time were: 6:00-8:59 A.M., 4 bites; 9:00-11:59 A.M., 16 bites; 12:00 noon-2:59 P.M., 22 bites; 3:00-5:59 P.M., 20 bites; 6:00-8:59 P.M., 20 bites; 9:00-11:59 P.M., 6 bites; 12:00 midnight-2:59 A.M., no bites; and 3:00-5:59 A.M., 1 bite.

Bite Victims.—There were 58 white males, 44 white females, one non-white male and one non-white female admitted to West Virginia hospitals for snakebite treatment during 1958 and 1959. The two non-whites were Negroes. Using the 1960 census of the population of West Virginia, the bite rates per 100,000 population were: 6.66 for white males, 2.28 for non-white males, 4.89 for white females and 2.15 for non-white

females. Thus, whites had higher snakebite rates than non-whites and males had higher rates than females.

The age distribution of West Virginia bite victims is shown in Table 2. The largest number of bites happened to children and youths 10-19 years of age (27 bites) and those 0-9 years of age (26 bites). Indeed 51 per cent of all snakebites were inflicted on children and young adults less than 20 years of age. Age-specific bite rates much more meaningful since they take into account the population at risk in a particular age group. The highest biannual bite rate per 100,000 population was found for those 10-19 years of age (7.49). The lowest bite rate was found among people 40-49 years of age.

An analysis of the occupations of the patients showed that 53 were children, 12 were housewives, 10 were unemployed, six were operatives, four were retired, three were professionals, and one each were clerical, sales workers and craftsmen. The occupation was not tabulated for the remaining bite victims.

Activity and Place.—Sixteen bites occurred while children were playing outside, 14 in their own yards and two elsewhere. An additional seven people were bitten while walking or working in their own yards. Four people were bitten while engaging in recreation other than hunting and fishing, three while handling a poisonous snake, three while picking up lumber or wood and one each while hunting and walking near a highway. The activity was not coded for the remaining patients.

The place where the bite accident happened is closely related to the activity when bitten. The largest number of snakebites, 21, happened right in the patient's own yard. Nine people were bitten in a field away from the house, seven in the woods, five in or under a house or building, and two in a field near the house. One bite happened in or near water and one near a highway. Of the five people bitten in a building, two people were bitten in the bedroom, two in the basement and one inside a church building during a religious ceremony. The place where the bite happened was not coded for the other patients.

Site and Severity.—The anatomical sites on human beings where venomous snakes inflicted their bites are shown in Table 3. Ninety-seven per cent of the bites were inflicted on the extremities—33 per cent on the upper extremities and 64 per cent on the lower extremities. The fingers and hands were the parts most often bitten on the upper extremities. The feet and lower legs, including the ankles, were the parts most frequently bitten on the lower extremities. A five-year-old girl was bitten on the forehead while playing in the yard. The site was not recorded for two patients.

A modification of the clinical classification of pit viper venenation by Wood, Hoback, and Green[5] was used to determine the severity of bites. Bites were classified as follows:

Grade 0—*No venenation.* Fang or tooth marks, minimal pain, less than 1 inch of surrounding edema and erythema. No systemic involvement.

Grade I—*Minimal venenation.* Fang or tooth marks, severe pain, 1-5 inches surrounding edema and erythema in first 12 hours after bite. No systemic involvement usually present.

Grade II—*Moderate venenation.* Fang or tooth marks, severe pain, 6-12 inches surrounding edema and erythema in first 12 hours after bite, systemic involvement may be present—nausea, vomiting, giddiness, shock or neurotoxic symptoms.

Grade III—*Severe venenation.* Fang or tooth marks, severe pain, more than 12 inches of surrounding edema and erythema in first 12 hours after bite, systemic involvement usually present as in Grade II.

The severity of venenation (venom poisoning) was classified as follows for 92 hospitalized cases: 21 (23 per cent) were Grade O; 39 (42 per cent) were Grade I; 17 (19 per cent) were Grade II; and 15 (16 per cent) were Grade III. For the remaining 12 hospitalized cases the severity of venenation was not stated. There was one death among the 104 hospitalized cases reported in this series, providing a fatality rate of one per cent. When one realizes, however, that about 47 per cent of all poisonous snakebite cases in West Virginia are treated on an out-patient basis, the true case-fatality rate probably is much less than one-half of one per cent. This is confirmed by the fact that there was only one snakebite death in the State during the ten year period, 1950-59.[1] This fatality involved a 53-year-old housewife who was bitten by a rattlesnake she was handling during a religious ceremony. The victim refused medical treatment and was pronounced dead-on-arrival at a hospital six hours after the bite. Contrary to popular belief, few patients die within the first few hours following a poisonous snakebite. About 70 per cent of them die from 6-48 hours after venenation takes place.[6]

The paradox of a high incidence of poisonous snakebites with a low case-fatality rate in West Virginia can be attributed to the high percentage of copperhead bites and the low percentage of rattlesnake bites, to the prompt availability of medical care, and to the effectiveness of snakebite therapy. Rattlesnakes cause more deaths

than any other poisonous snakes in the United States.[6] There were no deaths in the United States definitely attributed to copperheads from 1950-1959. This finding should not imply that copperhead bites are not occasionally serious or are not potentially lethal.

Treatment

The current treatment of North American pit viper (rattlesnake, cottonmouth moccasin and copperhead) bites includes both minor surgery and medical forms of treatment. A constricting band (tourniquet) should be applied lightly to the involved extremity several inches proximal to the bite. The constricting band should be applied only tight enough to occlude the superficial venous and lymphatic flow. *It should not occlude the arterial circulation* and it should be released every 10-15 minutes for a minute or two. As edema resulting from venom poisoning spreads, the constricting band should be advanced to keep just ahead of the swelling. The purpose of the constricting band is to impede the spread of venom until incision and suction can be used to remove the venom mechanically and/or until antivenin can be administered to neutralize the venom.

Incision and suction (I.S.) is effective in removing venom from experimental animals up to about 120 minutes after the venom is injected. The sooner it is used, the larger the amount of venom that can be removed. Suction should be used for about one hour. We have found the suction cups supplied in the Cutter and the Becton-Dickinson snakebite first-aid kits effective

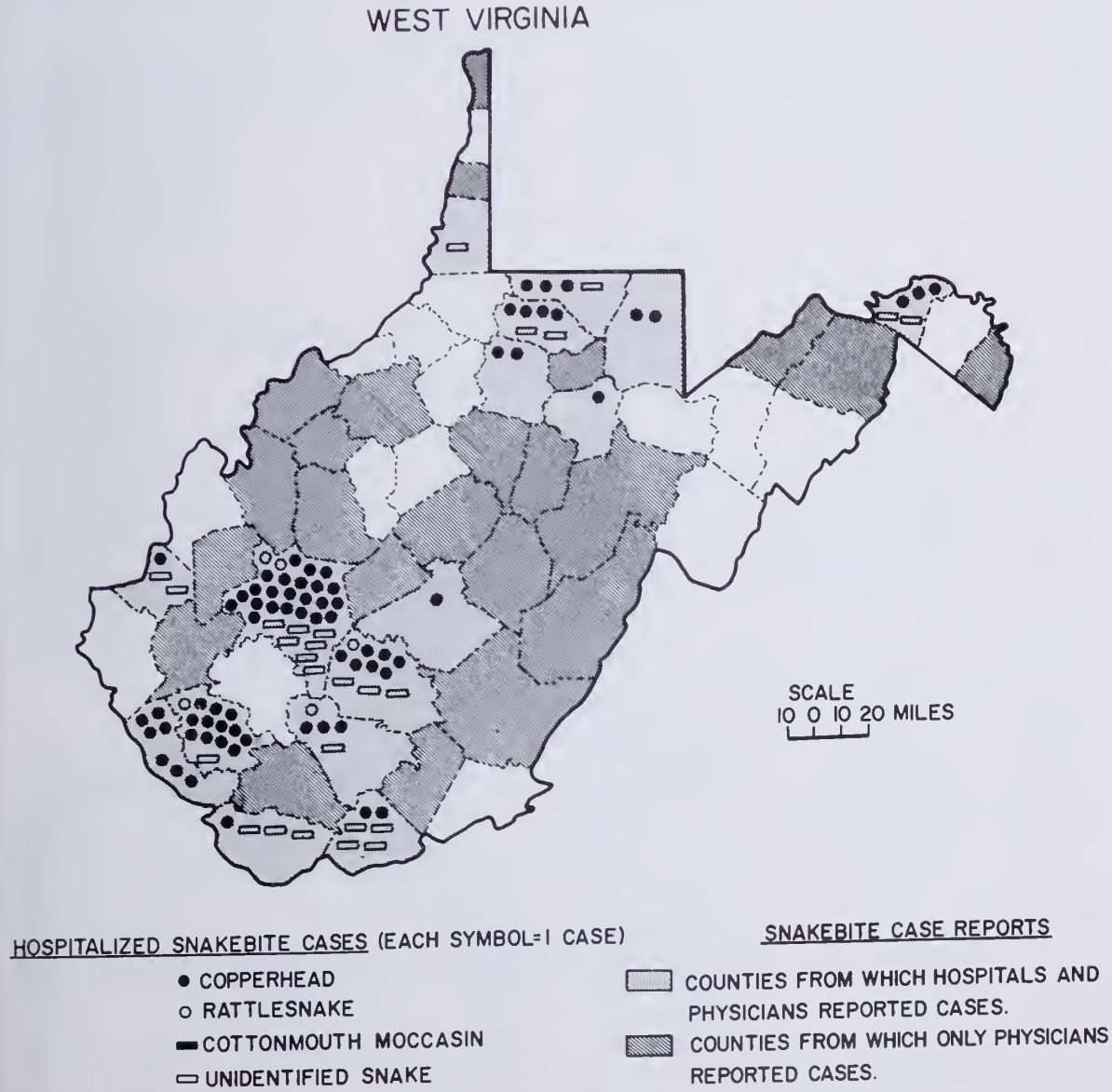

Figure 3. Geographical Distribution of Poisonous Snakebites in West Virginia, 1958 and 1959.

for removing pit viper venom. Incisions, one-quarter inch long and one-eighth to one-quarter inch deep, are made into the subcutaneous tissues over the fang punctures. A few (3-5) additional incisions may be made in the surrounding edematous tissues. A large number of incisions is not needed. Immobilization aids in limiting the spread of venom. However, if one must decide between immobilization or seeking prompt medical treatment, the latter should be sought.

The "3 A's" (antivenin, antibiotics, and tetanus antitoxin and/or toxoid) are recommended, in addition to I.S., in treating all serious pit viper bites. Antivenin Crotalidae Polyvalent (Wyeth) is effective in neutralizing the venoms of all North American pit vipers. It is not protective against coral snake venom. Since antivenin is manufactured from horse serum, the patient should receive a skin test before antivenin is given. For Grade I venenations antivenin may be administered in the deltoid or gluteus muscles. In Grade II and Grade III venenations, antivenin diluted in 1000cc. of normal saline may be given intravenously.[7] Studies with radioisotopes have shown that antivenin accumulates at the site of the bite more rapidly after intravenous administration than after intramuscular administration.[8] Injection of antivenin into the local bite area is not a particularly effective way to administer antivenin. We have found the following amounts of antivenin useful in treating the various Grades of venenation: Grade O (no venenation) requires no antivenin; Grade I (minimal venenation) may require 10cc. (one ampule) of antivenin; Grade II (moderate venenation) requires 30-40cc. of antivenin; and Grade III (severe venenation) requires 50cc. or more of antivenin.

Since snakes' mouths and venoms may harbor pathogenic organisms, antibiotics and tetanus antitoxin and/or toxoid should be given prophylactically. Gram negative organisms predominate, hence a broad spectrum antibiotic is indicated. Penicillin used by itself is not adequate treatment.

Cortisone and ACTH do not affect the survival rate of animals poisoned with pit viper venom. They probably should not be used during the first few days after venenation, although they may be beneficial later in treating serum sickness resulting from antivenin therapy. Antihistamines are contraindicated as they shorten the survival time of animals poisoned with pit viper venoms. Shock resulting from venom poisoning should be treated with infusions of blood, plasma, saline solution and vasopressor drugs. Meperidine hydrochloride and other analgesics may be given to relieve pain. Recently there have been reports of excessive tissue necrosis and amputations associated with cold therapy such a packing an extremity in ice or using ethyl chloride.[8] In my opinion, cold therapy should not be used in treating pit viper bites.

Summary

West Virginia has the third highest annual incidence of poisonous snakebites of any state east of the Mississippi River. An estimated 210 (111 in-patients and 99 out-patients) people were bitten by snakes annually—an incidence of 11.29 bites per 100,000 people. However, the

Table 1

Seasonal Distribution of Venomous Snakebites In West Virginia, 1958 and 1959

Month	*No. Bites*	*Month*	*No. Bites*
January	0	July	23
February	0	August	33
March	0	September	18
April	1	October	6
May	12	November	0
June	11	December	0

Table 2

Age Distribution of Hospitalized Snakebite Victims In West Virginia, 1958 and 1959

Age Group (years)	*Population at Risk**	*No. Bites*	*Rate per 100,000***
0 - 9	395,593	26	6.57
10 - 19	360,664	27	7.49
20 - 29	205,348	12	5.84
30 - 39	238,873	11	4.60
40 - 49	229,216	6	2.62
50 - 59	191,213	9	4.71
60 - 69	134,956	9	6.67
70 or more	104,558	4	3.83

*Based on the 1960 Census of the Population of West Virginia.

**These rates are only on hospitalized patients for whom information was available.

Table 3

Anatomical Sites of Bites Inflicted by Venomous Snakes in West Virginia, 1958 and 1959

Anatomical Site of Bite	*Side of Body Right*	*Left*	*Total No. of Bites*
Head, face & neck	0	1	1
Trunk, front	0	0	0
Trunk, back	0	0	0
Upper arm	0	0	0
Forearm	0	2	2
Hand	4	7	11
Fingers	16	5	21
Upper leg	2	0	2
Lower leg & ankle	16	13	29
Foot	17	11	28
Toes	5	3	8
Not stated	--	--	2

estimated case-fatality rate was less than one-half of one per cent.

Of 104 in-patients reported in detail by West Virginia hospitals during 1958 and 1959, 72 (69 per cent) were bitten by copperheads, 5 (5 per cent) by rattlesnakes, and 27 (26 per cent) by unidentified poisonous snakes. "Seasonal epidemics" of snakebites occurred with 99 per cent of the bites inflicted from May through October. August was the peak month for bites.

Males had higher bite rates than females and whites had higher rates than non-whites. Fifty-one per cent of the cases were among children and young adults less than 20 years of age. Ninety-seven per cent of the bites were on the extremities—33 per cent on the upper extremities and 64 per cent on the lower extremities. Current snakebite treatment is discussed.

Acknowledgment

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Hyperuricemia, Gout and Cerebrovascular Disease*†

John S. Meyer, M. D., George P. Kypros, M. D., and John Gilroy, M. D.

RECOGNITION of uric acid as an end product of metabolism dates from the isolation of uric acid from a urinary concretion by Scheele,[1] in 1776. Garrod,[2] in 1848, demonstrated an increased serum uric acid level in patients with gout and, in the last century, the biochemistry of hyperuricemia in relation to gout has been extensively studied. More recently, an association of abnormal serum acid levels with diseases other than gout has been established.

Uric acid (2-6-8 trioxypurine) is the end product of purine metabolism in man. It is excreted mainly by the kidneys but appears in smaller amounts in the sweat, saliva, bile and intestinal secretions.[1, 3] There are at least three possible mechanisms which can cause an elevation of serum uric acid levels: (1) excess purine biosynthesis, (2) abnormal renal tubular secretion of uric acid and (3) decreased intestinal urocolysis.[4]

Hyperuricemia is classically associated with gout and is said to be inherited as a simple mendelian dominant[5] although there is evidence that it may be caused by a number of genetic factors.[4, 6, 7] Elevation of serum uric acid, however, has been recorded also in hyperparathyroidism,[8] myxedema,[9] toxemia of pregnancy,[10] starvation,[11] high purine diet,[1] diabetes mellitus,[12] psoriasis,[13] blood dyscrasias,[14, 15] multiple myeloma, renal disease,[4] administration of chlorothiazide,[17] hydrochlorothiazide and acetozolamide,[18] mongolism,[19] and congenital deficiency of glucose-6-phosphase.[4] The possible relation of hyperuricemia to atherosclerosis is an old clinical observation, and a positive correlation between hyperuricemia and myocardial infarction has been reported.[20, 21] Any correlation, however, between elevated serum uric acid levels and cerebrovascular disease, to the best of our knowledge, has not been reported to date. This paper presents evidence of a correlation between hyperuricemia and a common occurrence of cerebrovascular disease. This finding is important since it offers a possible avenue of therapy in such cases of cerebral atherosclerosis by the use of uricosuric agents.

The Authors

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Material and Methods

Between September, 1962, and May, 1963, 145 persons with cerebrovascular disease were admitted to the Wayne Center for Cerebrovascular Research. As part of a detailed investigation of metabolic factors that might possibly contribute to cerebrovascular disease, 59 patients had serum uric acid estimations and of this group 19 were found to have persistent hyperuricemia unrelated to any drug therapy. The cases presented with signs and symptoms of completed stroke, stroke in evolution or transient cerebral ischemic attacks (carotid artery or vertebral basilar insufficiency). Arteriographic confirmation of cerebrovascular disease[22] was obtained in 18 of the 19 patients by retrograde brachial injection with separate injection of the left common carotid artery where necessary, so that complete visualization of the aortocranial circulation was obtained. In the remaining case, the diagnosis was based on clinical signs of brain stem infarction and a bruit over the right vertebral artery.[23]

The age range of patients with hyperuricemia was from 42 years to 81 years; 11 were males and 8 were females (Table I). Eight of the 19 had diabetes mellitus (Numbers 1, 2, 4, 11, 16, 17, 18, 19) and three gave a history of gout (Numbers 11, 12 and 14. All patients had a history of hypertension or had hypertension when examined. Patients with renal disease, however, or those who had had recent therapy for hypertension were excluded from this study.

Serum uric acid determinations were carried out, using the method described by Brown;[24] the upper limits of normal for this method are 7.0 mg. per cent of males and 5.0 mg. per cent of females.

*From the Departments of Neurology, Wayne State University College of Medicine, the Receiving Hospital, and the Wayne Center for Cerebrovascular Research. The study was supported by grants from the U. S. Public Health Service and the Research Corporation of the Receiving Hospital.

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Results

Of the 59 patients with cerebrovascular disease, 19 proved to have an elevated serum uric acid level, an incidence of 32 per cent. The ratio of males to females was 1.4:1, which is lower than that reported in gout and lower than the 7:1 ratio reported in cases of arterial and venous occlusion of the extremities.[3] Of 8 patients with diabetes mellitus and hyperuricemia, 5 showed normal serum cholesterol levels, 2 showed elevation of serum cholesterol, and in the remaining case, blood cholesterol levels were not obtained. Five patients, however, none of whom were diabetic, showed hypercholesterolemia as well as hyperuricemia. All females in this series were postmenopausal. One patient (Case 4) had undergone total hysterectomy with surgically induced menopause 10 years prior to admission. Although there does not appear to be an invariable association of hyperuricemia and hypercholesterolemia, abnormal levels of both substances were recorded in 36.8 per cent of the 19 cases.

Arteriography revealed involvement of the large extracranial vessels in 17 of the 19 patients with hyperuricemia. Of the remaining 2, one had generalized cerebral arteriosclerosis without involvement of the extracranial vessels; in the other case arteriography was not performed but an atherosclerotic plaque was present in the right vertebral artery (on clinical grounds). The carotid artery at the bifurcation was the most commonly involved vessel, with the vertebral artery at its origin the next most frequently involved.

A comparison of the arteriographic findings in the 19 patients with hyperuricemia and in the 40 patients without elevated serum uric acid showed a significant difference in the frequency of aortocranial atherosclerosis. Seventeen of the 19 hyperuricemic patients had involvement of the large aortocranial vessels by arteriography and in one of the 2 remaining patients such involvement was inferred on clinical grounds, giving a 94.7 per cent association between hyperuricemia and significant stenotic lesions of the neck vessels. In the 40 patients with normal uric acid levels, all of whom had arteriography, 14 (35 per cent) were shown to have significant disease in the aortocranial vessels, the remaining 65 per cent showing arteriosclerotic changes confined to the intracranial vessels.

An analysis of 36 cases of cerebrovascular disease treated at the Cerebrovascular Research Unit in the last two months shows an even higher rate of hyperuricemia than that reported in this study. The preponderance of patients with "surgically" accessible lesions of the aortocranial vessels in this group with hyperuricemia also has been maintained. It was decided to exclude these cases from this series, however, because there is an obvious inclination to refer patients for early arteriography if they show hyperuricemia having had one or more episodes of cerebrovascular

Table I

Case	*Diagnosis*	*Sex*	*Race*	*Age*	*Serum Uric Acid*	*Serum Cholesterol*
1	Bilateral vertebral occlusion	M	C	42	10.2 mg. %	240 mg. %
2	Bilateral carotid stenosis	F	N	65	8.2 mg. %	220 mg. %
3	Bilateral carotid stenosis Right vertebral stenosis	F	C	68	5.9 mg. %	
4	Left carotid stenosis	M	C	71	9.5 mg. %	237 mg. %
5	Bilateral carotid stenosis	F	C	72	6.8 mg. %	276 mg. %
6	Bilateral carotid vertebral stenosis	M	C	57	8.0 mg. %	208 mg. %
7	Left carotid stenosis	M	C	57	8.4 mg. %	228 mg. %
8	Bilateral carotid Left vertebral occlusion	F	N	47	7.5 mg. %	250 mg. %
9	Left vertebral stenosis	F	C	68	9.2 mg. %	256 mg. %
10	Bilateral carotid stenosis	M	N	81	9.8 mg. %	192 mg. %
11	*Vertebral stenosis	M	C	59	7.1 mg. %	224 mg. %
12	Left carotid stenosis	M	C	57	8.1 mg. %	164 mg. %
13	Right carotid and left vertebral stenosis	M	C	58	7.5 mg. %	310 mg. %
14	Left carotid stenosis	F	N	72	6.8 mg. %	252 mg. %
15	Left carotid stenosis	F	C	61	6.6 mg. %	308 mg. %
16	Left vertebral stenosis	M	C	58	7.5 mg. %	224 mg. %
17	Bilateral carotid stenosis	M	N	62	7.6 mg. %	372 mg. %
18	Generalized cerebral arteriosclerosis	M	N	62	8.6 mg. %	
19	Right carotid occlusion Left vertebral stenosis	F	C	80	7.7 mg. %	318 mg. %

*Clinical diagnosis. C = Caucasian. N = Negro.

insufficiency, and the admissions no longer represent an unbiased cross section of the population with cerebrovascular disease.

Discussion

The present study indicates that there is a significant incidence of hyperuricemia in cerebrovascular disease, often associated with hypercholesterolemia. Similar observations have been reported in association with atherosclerosis in other parts of the body,[3, 20, 21, 26] such as coronary and peripheral vascular atherosclerosis.

Uric Acid's Role Speculative

The part played by uric acid in the development of vascular disease is not known. At the end of the 19th century, French clinicians considered that there was an association between gout and atherosclerosis, and in English prints of the 18th and 19th centuries, the gout sufferer usually is portrayed as an apoplectic looking individual. Futcher,[25] in 1917, stated that the most commonly observed complication of gout was atherosclerosis while Osler,[26] from his wide autopsy and clinical experience noted that nearly all cases of chronic gout showed thickening of the arteries. In 1954, Traut,[27] demonstrated urate deposits in the walls of the coronary arteries and, later, Kramer and his co-workers,[3] recorded a high incidence of hyperuricemia in peripheral vascular disease. The proposition that there was relation between hyperuricemia and myocardial infarction arose from the work of Gertler and his colleagues,[21] in 1951.

A survey of the literature indicates that hyperuricemia is related to atherosclerosis generally with specific involvement of coronary and peripheral vessels. The present study establishes the same relation between hyperuricemia and cerebral atherosclerosis. Biopsy specimens of the plaques obtained at surgical reconstruction of the diseased arteries in several cases showed typical atherosclerotic plaques. While there are indications that some of the various humeral factors involved in arteriosclerosis may vary according to the site of involvement,[28] hyperuricemia appears to be associated with atherosclerosis in three widely differing sites: cerebral, coronary and limb vessels. This association justifies further investigation of hyperuricemia as one of the responsible factors in the arteriosclerotic diathesis.

The possibility that the raised serum uric acid levels were the result of cerebral infarction rather than its cause can be discounted since only 3 of the 19 patients had recent cerebral infarction and an additional 3 had a previous history of long-standing gout. The arteriographic findings show that the group of hyperuricemic patients have a high incidence of surgically accessible lesions, there being 17 of the 19 patients whose lesions were surgically remediable.

The hypothesis has been advanced that uric acid may act as a cationic surface which attaches itself to the larger cholesterol molecules and achieves adherence to the arterial intima.[21] The more factual views of Schrader and his associates[28] are widely accepted. These observers consider atherosclerosis to be a complex disturbance of blood lipid and other metabolic regulatory mechanisms and one of the complex factors involved is uric acid metabolism. In any event, it seems sound clinical judgment at this time to treat stroke cases in which there is hyperuricemia with hypo-uricemic agents such as probenecid and colchicine.

Summary

In a series of 59 cases of cerebrovascular disease (stroke), there were 19 (32 per cent) in which hyperuricemia was present. Eleven patients were male and 8 were females. In addition, diabetes mellitus was found in 8 cases. In 3 cases there was a history of gout. In all cases there either was a history of hypertension or hypertension was present on the initial examination. Hypercholesterolemia was present in 36.8 per cent of the hyperuricemic group. In 17 of the 19 cases there were surgically remediable lesions of the extracranial vessels of the neck.

The literature establishing the relation of gout to atherosclerosis elsewhere in the body is reviewed. The possible pathogenetic factors are briefly discussed.

It is concluded that gout and hyperuricemia predispose to atherosclerosis of the coronary, peripheral and cerebral vessels and that when hyperuricemia is detected in patients with cerebrovascular symptoms, it should be treated.

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Massive Blood Replacement*

Norman W. B. Craythorne, M. D.

The purpose of this paper is to draw attention to some of the hazards associated with massive blood replacement and to describe how they can be minimized.

The meaning of massive blood replacement will vary from one clinician to another. Since any quantity of blood in excess of ten pints constitutes total replacement of the circulating volume in the average 70 kilo man, it is proposed that a transfusion of five pints or more falls in the category of massive replacement. Obviously, a smaller quantity must be considered in infants and children in proportion to blood volume. In general, therefore, the risk of complications associated with transfusion of one pint of blood is multiplied at least five times with massive replacement.

Complications of Blood Transfusion

Febrile Reaction.—This is the most common complication and sometimes may account for chills and rigors often seen after anesthesia. It is known that incompatibility, either of the red or white cells, can produce pyrexia.

Allergic Reaction.—When an antigen is injected into a person who has the appropriate antibody, allergic reaction results. To prevent this in a patient with known allergy, an antihistamine can be administered one hour before blood is transfused. The antihistamine should not be added to the bottle of blood. When allergic phenomena do occur, they probably are best treated with diphenhydramine 25-50 mg.

Infected Blood.—Despite rigorous precautions to avoid contamination, deaths still occur from the transfusion of infected blood. Blood which has been warmed and cooled repeatedly or has been open for some time is more liable to infection than that which has been removed from the refrigerator once only and used immediately. It should be remembered that old blood has less bactericidal power than fresh blood. In no circumstances should blood be replaced in the refrigerator after it has been exposed to room temperature for more than thirty minutes. Despite these precautions, contamination to a pathological degree still can develop from growth of organisms which thrive at 4 C.[1] It is advisable to change the administration set every three or four hours.

Transmission of Disease.—The commonest disease and perhaps the most important is serum hepatitis. It develops from 6 to 160 days after transfusion, and the incidence of infected blood may be as high as one in every two hundred pints.[2] Other transmitted diseases include syphilis and malaria. Brucellosis also has been reported.

Toxic Factors in Plasma Including Anticoagulants.—Howland,[3] Bunker[4] and others have studied the effects of citrate intoxication on the cardiovascular system. Apparently this complication is only rarely associated with the slow transfusion of one or two pints but becomes of significance in massive replacement. It is more likely to occur with intra-arterial transfusions, under hypothermia, or in those patients with severe liver disease. After massive blood replacement, a clotting defect often is apparent. Various factors have been blamed for this, e.g., low serum calcium, absence of labile factors in stored blood, presence of circulating anticoagulants, hypothermia and absence of platelets in stored blood.

Over the past few years, the possible danger of high potassium concentration in the plasma of transfused blood has been debated. It is, however, generally agreed that the danger is real during rapid transfusion, particularly in children. On several occasions, the author has noted definite deterioration of EKG during rapid transfusion in small children. This can be minimized by using the freshest blood available. In cardiovascular surgery, means are sometimes available for rapid injection of blood directly into the atrium to replace sudden severe blood loss. An additional hazard is thus introduced, since cooling of the heart is thought to predispose toward

The Author

- **Norman W. B. Craythorne, M. D., Associate Professor and Chairman, Division of Anesthesiology, West Virginia University School of Medicine, Morgantown.**

*Presented before a meeting of the West Virginia Society of Anesthesiologists, held during the 96th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 22-24, 1963.

ventricular fibrillation.[5] In such circumstances, every effort should be made to use fresh, warmed blood.

Air Embolus.—When an air pump is used with the standard glass transfusion bottle, air embolus always is a possibility. Despite the best intentions, air embolus can occur unnoticed at that moment when blood pressure is rapidly failing, blood loss is severe and continuing and lightening anesthesia may be allowing the patient to move and engage the anesthesiologist's attention. All blood collected at the West Virginia University Medical Center is stored in plastic bags. Plastic bags reduce the risk of air embolism almost to zero, since blood can be pumped by compression, and there is no air space. When blood is supplied in a bottle, it is now our practice to transfer it to a plastic bag immediately before administration.

Mismatched Transfusion.—During massive blood replacement, the risk of transfusing mismatched cells is increased for two reasons: (1) The greater the number of units used, the greater is the risk of mistake. (2) After 10 or 20 pints of blood, the patient has had an "exchange transfusion" and his blood no longer may be of exactly the same type as before. It is advisable, therefore, to send a freshly drawn sample of blood to the laboratory for repeat cross matching after each five pints of blood given. There also is the possibility that different units of blood, while they may not react to the patient's blood, may react to one another. This risk also increases with the number of units transfused. Early diagnosis of a hemolytic transfusion reaction under anesthesia is essential. The commonest signs are cyanosis, uncontrollable oozing from the wound, hypotension, hypertension and tachycardia. Any one of these signs, or a combination of them, should suggest the possibility of mismatched transfusion. Further proof can be obtained by estimating free hemoglobin in the plasma or urine. There is, however, one type of case in which this diagnosis is extremely difficult to make, and that is the patient who has had cardiac surgery with the use of the pump oxygenator. Such a patient often is cyanosed from cold or disease; oozing may be present from increased venous pressure or the transfusion of large amounts of properly matched blood; he may be hypotensive for other good reasons or even occasionally hypertensive; he often may have tachycardia unrelated to transfusion; there is invariably free hemoglobin in the plasma and urine. There is no way of confirming a diagnosis of mismatched transfusion in these circumstances.

Temperature of Transfusion.—The value of warming blood before transfusion has been controversial for several years. There are those who believe that by warming the whole pint of blood, the risk of infection of that blood is greatly increased, especially when there is some delay between warming and transfusing. This undoubtedly is true. A better method is to warm the blood in the tubing leading from the transfusion bottle to the patient by passing it as a coil through a plastic container containing water at 37C. Howland[6] has shown that warming the blood raises the pH towards normal and leads to the rapid return of potassium into the cells. Considerable inconvenience from hypothermia has been experienced after the transfusion of large volumes of cold blood. This is more common in children and it is most difficult to prevent dangerous degrees of hypothermia in pediatric cases. A warming blanket is almost ineffective in combating this type of hypothermia in children. For this reason alone, a blood warmer probably is a worthwhile acquisition.

Incorrect Estimation of Blood Loss.—Most anesthesiologists have had patients who have lost large amounts of blood and in those cases replacement of the same volume of blood or even much more did not restore the blood pressure to normal levels. Jenkins and Moyer[7] have shown that in certain cases of shock from blood loss, transfusion of blood alone will not restore blood pressure and, in fact, may lead to congestive atelectasis. At autopsy in some of these cases, the lungs had a solid appearance rather like liver. These observers have shown that infusion of lactated Ringer's solution as part replacement of loss of circulating volume results in improvement in the patient's condition and in the return of normal blood pressure. It should be remembered that in an emergency, lactated Ringer's solution will maintain blood pressure for a reasonably long time, can be given more quickly than most stored blood, is safer because it is free from all the inherent dangers of blood transfusion and, when given in excess, can be excreted more easily by the kidneys. One way of preventing congestive atelectasis is to evaluate carefully the blood loss and avoid the risk of overloading the circulation.

Measuring Blood Loss

There are several methods for measurement of blood loss: (a) Weighing of sponges and measuring the amount of blood in suction bottles probably remains the best practical method available. (b) Electronic devices for measuring the conductivity of fluid in which all sponges and aspirated blood have been placed are available but are not widely used. (c) In open heart sur-

gery, one method is to weigh the patient before and after surgery. Any difference is presumed to be the result of blood loss or gain. It should be remembered, however, that one or two pints of blood can be lost from the circulation into the thoracic cavity, yet not be accounted for by this method. (d) Howland[8] has suggested that decreased plasma standard bicarbonate levels may be used as an indication for further blood transfusion. This is a method which is not easily available to most anesthesiologists, and I have considerable doubt as to its value for the average practitioner. Interpretation of data is much more difficult by this technique than by any of the others discussed. (e) Blood volumes can be estimated before, during and after surgery. Most of the techniques for measuring blood volume are inaccurate and the error can be in the order of 500 to 1000 ml., even in those patients undergoing minor surgery. This method is not recommended when used alone. (f) The monitoring of vital signs is of utmost importance. These include capillary refill, arterial systolic and diastolic blood pressure, pulse volume and rate, urinary output and the general appearance of the patient. Proper attention to these signs usually ensures a safe clinical course.

In every case the total amount of blood transfused should be kept at a minimum. There are several ways to do this safely. Circulating volume can be maintained with other fluids as well as blood. At this institution, it is the custom to substitute one pint of lactated Ringer's solution for every fourth pint of stored blood. Hypotensive techniques will reduce the amount of blood loss in certain operative procedures. Hypothermia also keeps blood loss at a minimum. Occasionally, these techniques are combined with good effect. During many operations much of the blood loss is from the venous side of the circulation. Careful positioning of the patient on the operating table can reduce this blood loss markedly.

Summary

The risk of blood transfusion is not small. Most blood banks estimate that there is one fatality for every 1,000 transfusions. In many hospitals where technical facilities are limited, mortality rates may be even higher.

Massive blood replacement carries an even greater risk than the average transfusion. Reasons for this are discussed. It is, therefore, the responsibility of the physician to take all possible precautions to minimize the danger to the patient and to minimize the need for such replacement.

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Physical Fitness

The ancient art of ambulation has come into much publicity in recent months due to the late President Kennedy's "keep fit" program and there was good sound thinking in Mr. Kennedy's suggestion. Walking is good exercise, effective in toning up and strengthening the muscles, particularly the legs, and it does push the participant out into the fresh air rather than wrestling barbells in the basement. The exercise is not so strenuous as to be dangerous as is the case of the snow-shoveler or the weekend skier who leads a sedentary life six days a week.

Previous Presidents have also been walking enthusiasts. Eisenhower, even with his golf go-cart, does a great deal of walking on the green fields of both the fairway and the farm—and this, "post-infarction"; and Truman, with his morning constitutionals, walked the socks off of dozens of panting reporters.

Doctors who exercise and walk for their own enjoyment and good health are to be commended. But as in all off-duty avocations—whether wine, women or walking—moderation is essential!—Rocky Mountain Medical Journal.

Mental Health Planning in West Virginia*

Mrs. John W. Hash

IN 1955, the Joint Commission on Mental Illness and Health was formed "by the American Psychiatric Association and the American Medical Association under the stimulus of Dr. Kenneth E. Appel, Dr. Leo H. Bartemeier and other psychiatrists who shared a dismay at the stopgap, piecemeal and generally planless and unsystematic way in which mental services were being organized and operated, even in States where an attitude of urgent need and desire for progress had clearly emerged."

Later in 1955, Congress passed the Mental Health Study Act—an act which was "adopted by Joint resolution without a dissenting vote . . . the senators and representatives recognizing a critical need for an objective, thorough, nationwide analysis of the human and economic problems of mental illness and the methods of solving these problems." The act specified that this project must be carried out by a "non-governmental, multi-disciplinary group or groups." Thus, other members of the mental health professions, and leaders from other groups with a professional or a public interest in mental health progress, were selected by the National Institute of Mental Health to serve with the psychiatrists.

In 1960, the report of the Joint Commission was sent to Congress along with a letter of transmittal signed by Drs. Appel and Bartemeier. The following statement is contained in that letter: "Mental illness involves so many complexities—biological, chemical, psychological, and social—that we do not presume to present wholly definitive conclusions or universally approved recommendations. But the study has been thorough and conscientious. Its proposals are bold and challenging. It remains for legislators and leaders in the mental health field to select for implementation those recommendations that seem immediately practicable and to press for the realization of others so far as they appear urgent and attainable."

The report was published in 1961 under the title "Action for Mental Health." On July 2, 1962, the Governor's Conference, in session in Hershey, Pennsylvania, adopted a resolution recognizing that "a great deal of interest and attention has been created by the Final Report of the Joint Commission on Mental Illness and Health" and resolved that "each state develop a comprehensive master plan for coping with mental disability and promoting mental health that will mobolize state and local, private and voluntary resources, and stimulate greater community initiative and provide a long-term basis for meeting this great human responsibility."

The Author

- **Mrs. John W. Hash, Charleston, W. Va., Temporary Chairman, Governor's Advisory Committee for Mental Health Planning.**

In October of 1962, for the first time in its history, the American Medical Association held a Congress on Mental Health. Approximately 2,000 persons, including nine from West Virginia, attended the meeting and worked hard at sharing problems and solutions, with the ultimate aim of providing further resource materials and a vehicle for shaking up traditional mind sets as we began to develop our own master state plans.

In 1963, Congress provided for a new program in mental health by appropriating $4,200,000 specifically allocated for matching planning grants to states to develop comprehensive mental health plans based on the needs of the state as related to the major recommendations of the report of the Joint Commission on Mental Illness and Health.

On March 26, 1963, Dr. Mildred Bateman, Director of the West Virginia Department of Mental Health, concluded a rather lengthy transmittal letter with West Virginia's Planning Proposal with these words: "Your favorable consideration of our application will be greatly appreciated." Probably the understatement of the year. On July 16, 1963, our application was approved, our grant was received and planning activities were begun.

Our State's plan designates:

For Leadership—a statewide, 130 - member Governor's Advisory Committee.

*Presented before the Annual Meeting of the West Virginia Welfare Conference in Clarksburg, April 24, 1964.

For Implementation—an enormous group and individual involvement of lay citizens.

For Coordination—a special staff.

Now formed and functioning, the organization has four parts:

(1) Regional committees in seven inclusive state areas.

(2) Task Forces for intensive work on acute mental illness, chronic mental illness, emotionally disturbed children, mental retardation, alcoholism, the aged and implementation.

(3) Local county committees stemming from each regional committee.

(4) Forty-eight Mental Health System staff members assigned as resource persons to regional, county and task force groups.

The goals are to develop statewide community mental health services through planning toward:

Early Diagnosis and Prompt Treatment—as given by psychiatrists, other physicians, outpatient facilities, general hospitals and specialized psychiatric facilities, and counseling.

Follow-up and Rehabilitation—for discharged and on-leave mental hospital patients.

Consultation Services—to schools, courts, public and private health and welfare agencies.

Public Education—using mass media, group education and schools.

Research—into causes of mental and emotional disorders; into community conditions contributing to these and into new mental health programs to meet the needs.

Activities essential to the planning process include:

Gathering Information—by channeling it from local to regional Committees, then to the planning coordinator to interpret pooled data. We will then be using the information to form conclusions as to (a) what mental health services are needed and where; (b) establish priorities: which are most needed and in what order; and (c) how to develop them.

Our timetable calls for a Statewide Progress Report on the Planning Program due June 1, 1964, and a Blueprint of a Plan by Fall of 1964. The Mental Health Planning Program is headed by Governor W. W. Barron, and he appointed your speaker as Temporary Chairman. (The permanent officers for the Governor's Advisory Committee for Mental Health Planning were elected at a general meeting which was held in Charleston on May 15).

Our Executive is Dr. Mildred Bateman, Director of the West Virginia Department of Mental Health, and Robert E. Marshall serves as Coordinator. The main thrust of the planning is carried on by West Virginia citizens, individually and in organizations. The West Virginia Association for Mental Health contributes much as does the West Virginia Association for Retarded Children. By the very nature of the problem, however, programs which will be community undertaken and community oriented plainly and urgently need endorsement of and participation by members of the West Virginia State Medical Association.

It is hoped that this joint participation will serve to strengthen the community's capacity to recognize its mental health needs, identify its problem areas, and mobilize itself to solve these problems; facilitate cooperative relationships between individuals, groups, institutions, and organizations significant for mental health; and modernize achieved goals by adjusting or modifying existing services and programs as the community changes.

The goal, the idea, the concept is that in the future West Virginia will provide comprehensive services for all mentally ill—close at hand, available without waiting and coordinated to work relatedly.

In the Workbook for Regional Chairmen, our Coordinator, Mr. Robert E. Marshall, has quoted from the Southern Regional Education Board report "Committment to Health," saying that these quotes might well serve as the goals for our Mental Health Planning.

"To prevent mental disorders from occurring and to prevent needless disabling to those who already suffer from them.

"To provide the best care for the mentally ill and retarded that our knowledge equips us to give, and

"To help strengthen those forces in the community from which we derive the capacity to live productively and tolerate the stress and strain of living."

West Virginia needs all of its men and women. The hundreds of West Virginians participating in the work of the Governor's Advisory Committee have not only compassion for their fellowmen but a desire for the thrifty conservation of human resources so important to the future of our State.

Our late President said: "For too long the shabby treatment of the many millions of the mentally disabled in custodial institutions and many millions more now in communities needing help has been justified on grounds of inadequate funds, further studies and future promises. We can procrastinate no more."

Through faith, skill and a uniquely shared effort, we shall succeed!

97TH ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 20-22, 1964

Plan to Attend — Make Your Reservation . . . Now !

The President's Page

Progress, Excellence and Freedom

THE three necessities of an enlightened civilization are progress, excellence and freedom. The environment must be suitable for *all* three as they are interdependent. Most rational and idealistic men, both individually and as group members, acknowledge and accept these factors as the ultimate goal for every aspect of life, if we are to attain these high levels of human endeavor.

There are many influences within our modern society which would discourage and even suppress any or all of these three ideal necessities. These suppressing influences are not new, but have existed through past centuries wherever there has been the desire of the few to dominate. The latter has been accomplished either through a form of dictatorship, or another form of despotism combining with the facade of freedom and establishing itself under the guise of the sovereignty of the people, that we know as paternalism.

To the realist this is the cause of great apprehension. Paternalism is an influence predicated on the assumption that the general welfare, as determined by planners, should take precedence over the liberties of individuals. It is opposed to individuality and free growth, and indeed to human nature itself.

Progress, excellence and freedom have always been the natural enemies of paternalism because they cannot live and grow in this atmosphere. The method used by the collectivists to deal with these enemies is one of slow strangulation. Any limitation of freedom must inevitably restrict progress, and the "equalitarian oppression" will suppress excellence. The natural evolution of the finer and constructive aspects of man's nature is defeated as a result.

We are being piloted along a course where the medical profession, most of our educational system, and the greater part of our scientists will be slowly absorbed under the *all* protecting power of a paternal government. We as physicians, and all other men, who believe in the right of the individual's free pursuit must remember that no man or group of men can hope to direct the creative energies of a nation without diverting those energies into the safe, easy and traditional patterns so congenial to administrators that are inherent in any paternalistic system of government.

The medical profession must continue to take the initiative in the struggle against a welfare state, and advocate the strengthening of the individual's rights over so-called collective welfare. We must strengthen those intermediate powers, our own private institutions with authorized, limited powers, which stand between government and ourselves.

The individual physician must maintain and protect his power to choose, the exercise of his free will. In this atmosphere he observes, measures, tests, evaluates and then selects. It is only when he retains this freedom that he can fulfill the role of the true physician, and attain his highest efficiency and excellence.

The organized medical profession must therefore continue through concerted effort to inform the public concerning the urgency and necessity for protecting these self evident truths—progress, excellence and freedom. This must be accomplished by utilizing all avenues of communication, and enlisting the support of men of similar ideals and convictions.

Charles L. Goodhand

Charles L. Goodhand, M. D., President

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EDITORIALS

SOME PROBLEMS IN MEDICAL LICENSING IN WEST VIRGINIA

The right to practice medicine is a sovereign right bestowed upon qualified physicians who can fulfill the requirements of the Medical Practice Act of West Virginia. It is a property right awarded only after thorough investigation of the applicant's credentials. It cannot be withdrawn except for fraud in procurement of the license, habitual drunkenness, gross immorality, conviction of a felony, or habitual use of narcotics.

West Virginia law permits a physician to obtain a license through reciprocity with any other states that grant equal courtesies to West Virginia licensees. An applicant may secure a license through endorsement of National Board credentials or a qualified applicant may secure a license by passing an examination on subjects prescribed by the Medical Practice Act.

The law states that the practice of medicine by unlicensed individuals constitutes a felony. Stetler, in *The Handbook of Legal Medicine,* states "the practice of medicine by an unlicensed person or the aiding and abetting of an unlicensed person to practice medicine constitutes a criminal offense." Furthermore, the illegal practice of medicine is an assault on the public and private health of West Virginians.

Regulation of medical practice is not difficult when confined to graduates of American medical colleges. For many reasons, beginning with the dire predicament of physician refugees, the vast increase in hospitals with desirable residencies in the United States, the lack of interest by American graduates in institutional practice, rural economics, and the image of this country as a haven of freedom and opportunity, the United States has seen a tremendous influx of foreign medical graduates with the result that foreign schools now provide 20 per cent of all medical licensees. In West Virginia more than 50 per cent of the residents now in hospital training are graduates of foreign medical schools.

Many foreign graduates come to the United States on exchange visitor's visas. These physicians must return to their native lands in five years. After a two-year sojourn in the homeland they may return to the United States on a permanent visa. Saturated with practice opportunities in this country, many of these graduates are able to short cut the legal requirements. Other foreign physicians enter the country originally on a permanent visa and are available immediately for private practice.

There should be some means whereby foreign medical graduates could be considered for temporary licensure on an individual basis. But this has been found impractical and impossible in most states. There are about 265 foreign medical

schools from which we accept diplomas and there are many others in China, Cuba and other Communist countries where it is impossible to secure satisfactory validation of the graduates' medical education and qualifications.

Some medical schools in Europe are the equal or perhaps superior to the average approved medical school of the United States or Canada. A great many of the schools in Europe, Asia and Africa, however, are "diploma mills" and vastly inferior to any medical school in this country.

In order to cope with the many problems of licensure, the Medical Practice Act of West Virginia provides special provisions for the licensing of foreign medical graduates. Regulations developed by the Medical Licensing Board and approved by the Office of the Attorney General have been adopted for the control of unlicensed foreign medical graduates in our hospitals and institutions. All foreign medical graduates who seek a permanent license must have their credentials carefully authenticated by a special committee of experts on medical education at West Virginia University.

Following this system, 84 foreign graduates have been fully licensed in West Virginia since 1951. Most of them are still in the State, in urban specialty practice, while a few are practicing in rural areas. As of May, 1964, there were 213 foreign graduates in our hospitals and State institutions. Most of them are in positions that would be vacant if foreign graduates were not available.

Because of the lack of sufficient personnel on licensing boards throughout the United States to adequately study credentials, there was developed in 1958 an Educational Council for Foreign Medical Graduates, more commonly known as the ECFMG. This Council was formed through the cooperation of the American Medical Association, American Hospital Association, the Association of American Medical Colleges and the Federation of State Medical Boards of the United States. This Council has qualified personnel to examine credentials and prepare examinations that will suitably test the medical ability of physicians. Examinations are held semi-annually in the United States at 30 medical centers and in 70 foreign countries.

Any graduate of a medical school listed by the World Health Association is eligible to apply. Temporary certificates of two years' duration or permanent certificates are granted to the successful candidates. In October, 1964, the temporary certificate will be discontinued. An ECFMG certificate is required for any physician who accepts an appointment in an approved residency or internship program.

The American Hospital Association denies registration to any hospital having on its staff in a patient-care situation any foreign graduate who does not have this certificate. The Joint Commission on Accreditation of Hospitals will not approve a hospital which employs a foreign graduate without an ECFMG certificate. The only exception to the above is when the foreign graduate has an unrestricted medical license from any state or is engaged in purely laboratory research.

The MLB of West Virginia abides by the above requirements by necessity, except in one area of real medical need. The MLB has granted to our State institutions the right to employ foreign graduates who do not hold the ECFMG certificate. This provision was adopted only after prolonged study and with deep regret. It was permitted purely on the basis of genuine necessity. Our State institutions could not have had even the present numerically inadequate staff if there was strict adherence to regulations. None of these institutions are approved by the Joint Commission on Accreditation of Hospitals and most of them have a fully licensed physician in charge who must exert continuous observation of his staff. The credentials of this group of physicians have been investigated as far as the resources of the MLB will permit. They are required to apply for full licensure as soon as their residency and citizenship qualifications are in order. Even under this rigid system mistakes can occur and recently an impostor was assigned to a State institution. He professed to be a Cuban medical graduate and had credentials which were in order, but which allegedly were stolen. The MLB has had great sympathy for Cuban medical refugees and has extended regulations as far as the law would permit to accommodate Cuban physicians in West Virginia. Further regulatory devices make it improbable that such an incident may reoccur.

Eight foreign graduates were recently discovered in a West Virginia city practicing medicine illegally. Classified as externs, they were, or professed to be, foreign medical graduates. They had no practice permits, no State license and no ECFMG certificates. They were not laboratory researchers and had no other state license. They were practicing in fully accredited hospitals, and some of them had been in hospital work for many months but had never applied to the MLB for a temporary license.

All hospitals are regularly notified of any change in licensing provisions pertaining to foreign graduates. The last communication to all hospitals concerning these regulations was on November 20, 1963.

It is a peculiar commentary that when these eight foreign graduates engaged in the illegal practice of medicine were uprooted, most of the reaction of the press, the public and indeed many physicians was one of sympathy for the foreign graduates and criticism of the MLB.

Such illegal practices are unfair to the public, place the accreditation of the involved hospitals in jeopardy and have explosive medical liability possibilities.

The MLB has no money to employ investigators, supervisors or sufficient trained personnel to meet the complexities which have developed through the investigation and licensure of foreign graduates. The operating revenues of the Board are derived from the $2 biennial registration and license fees. The total of these funds is quite inadequate for maximum efficiency.

Recently the MLB has held conferences with appropriate committees of the West Virginia Hospital Association and the West Virginia State Medical Association in an effort to solve their mutual problems. All three are greatly concerned with the scarcity of physicians in all types and areas of practice in the State. They are equally concerned with their solemn obligation to protect the citizens of this State from poorly trained physicians, impostors and illegal practitioners.—G.F.E.

HARRISON COUNTY SCHOLARSHIP PROGRAM

On May 7 the Harrison County Medical Society brought into being its own scholarship foundation with $11,400 collected from polio clinics and, together with a donation of $600 from the Society, there was an initial endowment of $12,000. Through the management of the Empire National Bank of Clarksburg, a loan potential of $120,000 has been developed. The Bank will loan at the rate of $10 for each $1 deposited.

This fund will provide loans at reasonable interest rates to students of Harrison and Doddridge counties who are enrolled in any institution of higher learning in the United States. The loans are not confined to pre-medical or medical students.

The fund will be administered by four members of the local medical society, an official of the Empire National Bank, a representative of the County Board of Education and the President of the Board of Education of Notre Dame High School. Further donations are encouraged from interested individuals and organizations and it will be the policy of the local medical society to increase its financial interest in the project as demand develops.

Applicants will be screened by a committee of the Harrison County Medical Society. If approved, an applicant will be able to borrow $1,500 per year up to the limit of $4,500. Applicants must be full-time students and must have completed one semester of college work.

The announcement was made by Dr. A. Robert Marks, President of the Harrison County Medical Society, and Dr. Sobisca S. Hall, Chairman of the College Student Loan Fund.

The loan fund is patterned to some extent after the AMA-ERF and the USAF program, but is unique in that it is locally administered. The future development of this program will be watched with great interest throughout the State.

Postgraduate Education for GPs

Recently in England, a report from the "Research Project on Prescribing," University of Liverpool, which deals with "the extent to which a doctor interprets and correlates his scientific information when he is applying it to the needs of individual patients", has been published.

The report is concluded by these observations: "Medical training, the pharmaceutical industry, the *British National Formulary* and consultants were each employed to provide over 20 per cent of the information which general practitioners need for treating their patients. Information from the drug industry was used for 60 per cent of the diseases."

Our observations over the years would lead us to believe that what was found to be true in England, is probably true in the United States. It points up beyond doubt the large contribution which the pharmaceutical manufacturers are making to the postgraduate education of family physicians in this country.

In this effort the industry should be aided in every way by investigators, and government, so that correct clinical therapeutic information may be quickly made available to those who treat the bulk of disease, the family physicians of the United States—Perrin H. Long, M. D., in *Medical Times*.

In the past 20 years life expectancy has been increased by almost 20 per cent. Better drugs, along with better nutrition, improved medical care and public health and sanitation measures, have increased life expectancy from 59.7 years in 1930 to 62.9 years in 1940 to over 70 years today.

GENERAL NEWS

Plans Nearing Completion for Annual Meeting at The Greenbrier

Two prominent physicians have accepted invitations to appear as guest speakers at the 97th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 20-22.

Dr. William E. Gilmore of Parkersburg, Chairman of the Program Committee, said that Dr. Anthony F. DePalma of Philadelphia and Dr. Eugene F. Poutasse of Norfolk, Virginia, will present papers during the three-day meeting.

Doctor DePalma, who has served since 1950 as Professor of Orthopedic Surgery at Jefferson Medical College in Philadelphia, will appear as a speaker at the second general session on Friday morning, August 21.

Eugene F. Poutasse, M. D.

Anthony F. DePalma, M. D.

Doctor DePalma was born in Philadelphia and he received his M. D. degree in 1929 from Jefferson Medical College. He interned at Philadelphia General Hospital, 1929-31, and served a residency at the New Jersey Orthopaedic Hospital, 1932-39.

He served in the Medical Corps of the United States Navy during World War II and was Chief Orthopedic Surgeon at the U. S. Naval Hospital in Philadelphia. He held the rank of Commander at the time of his return to civilian life in 1946.

Doctor DePalma is a Diplomate of the American Board of Orthopaedic Surgery and a member of the American College of Surgeons. He is a Fellow of the American Academy of Orthopedic Surgery and the Association of Bone and Joint Surgeons.

He is the author of four books and numerous papers which have appeared in scientific journals. He is currently serving as Editor-in-Chief of *Clinical Orthopaedics* and as a member of the Editorial Board of *American Practitioner.*

Eugene F. Poutasse, M. D.

Dr. Eugene F. Poutasse, who is associated with the Devine-Poutasse Urological group in Norfolk, Virginia, will appear as a speaker at the first general session on Thursday morning, August 20.

Doctor Poutasse was born in Weston, Massachusetts, and was graduated from Harvard College. He received his M. D. degree in 1943 from Harvard Medical School.

He interned at Peter-Bent Brigham Hospital and served for three years in the Medical Corps of the United States Navy. He served residencies at Peter-Bent Brigham Hospital and Cleveland Clinic Foundation.

He joined the Staff of Urologic Surgeons at the Cleveland Clinic Foundation in 1950 and served there until he moved to Norfolk early in 1964.

He is certified by the American Board of Urology and is a member of the American College of Surgeons and the American Association of Genito-Urinary Surgeons.

Doctor Poutasse was elected in 1963 to a three-year term on the Board of Governors of the American College of Surgeons as a representative of the American Urological Association.

Plans for Two General Sessions Completed

Plans for the first two general scientific sessions have been completed. In addition to Doctor Poutasse, the speakers at the first general session on Thursday, August 20, will be Dr. Bayard Carter, Professor of Obstetrics and Gynecology at the Duke University School of Medicine, and Dr. John M. Howard of Philadelphia, Professor of Surgery at Hahnemann Medical College.

In addition to Doctor DePalma, the speakers on Friday morning will be Dr. Waldo E. Nelson of Philadelphia, Professor and Head of the Department of Pediatrics at the Temple University School of Medicine, and Dr. John C. Krantz, Jr., Professor and Head of the Department of Pharmacology at the University of Maryland School of Medicine.

Dr. Perry E. Gresham, President of Bethany College, will be among the honor guests and will appear as a speaker at the opening of the first general scientific session on August 20.

Dr J. H. Walker, Mrs. A. C. Chandler Honored by Public Health Assn.

Dr. James H. Walker and Mrs. A. C. Chandler, both of Charleston, were honored recently by the West Virginia Public Health Association for outstanding achievement in the field of public health in West Virginia.

Doctor Walker was presented the "Merit Award" and Mrs. Chandler the "Citizen's Award" at the 40th annual meeting of the Association which was held at the Daniel Boone Hotel in Charleston, May 6-8.

Native of Charleston

A native of Charleston, Doctor Walker is Chief of Thoracic and Cardiovascular Surgery at Charleston Memorial Hospital. He also is thoracic surgeon at Hopemont Sanitarium, consultant in cardiovascular surgery for the Division of Crippled Children's Services of the West Virginia Department of Welfare and part-time director and consultant for the Bureau of Tuberculosis Control of the State Department of Health.

Mrs. Chandler, wife of a Charleston physician, has long been active in community projects. She has been a member of the Board of Directors of the Children's Home Society of West Virginia since 1948, serving as its president for three terms. In addition, she is a member of the Kanawha Welfare Council, the Governor's Advisory Council for Mental Health, Woman's Auxiliary to both the Kanawha Medical Society and the West Virginia State Medical Association.

State Director of Health Dr. N. H. Dyer, center, is shown with Mrs. A. C. Chandler and Dr. James H. Walker, both of Charleston, after he presented them with plaques for outstanding achievement in the field of public health in West Virginia. The presentations were made at the annual meeting of the West Virginia Public Health Association in Charleston.

New Officers Named

Mr. James C. Rosencrance of Charleston was installed as president of the Association, succeeding William H. Lively, also of Charleston.

Dr. Roger P. Elser of Charleston was named president elect; and Guido Iannarelli of Charleston and Mrs. Delores Summers of South Charleston, were elected vice president and treasurer, respectively. Mrs. Katherine L. Brown of Charleston serves as executive secretary.

Dr. O. W. Ladwig of Wilsonburg W. Va. 'GP of the Year'

Dr. O. W. Ladwig, 88, of Wilsonburg, is West Virginia's "General Practitioner of the Year" for 1964. The selection was made by the Council of the West Virginia State Medical Association from a field of nominees submitted by component societies. Final action was taken by the Council at the Spring meeting in Charleston on May 3.

O. W. Ladwig, M. D.

Doctor Ladwig, who is still active after 59 years of practice, will accept the award during the 97th Annual Meeting of the State Medical Association at The Greenbrier in White Sulphur Springs, August 20-22.

He was born at West Milford on October 11, 1875, the son of Hermann and Mary Romine Ladwig. He was graduated from Fairmont Normal School in 1901 and taught in Harrison County Schools before receiving his M. D. degree in 1905 from the Louisville Medical College in Louisville, Kentucky. He had post-graduate training at the New York Post-Graduate Medical School.

Doctor Ladwig began his practice in 1905 at Lost Creek in Harrison County. He also practiced at Walkerville and Evenwood before moving to Wilsonburg in 1922.

He served as vice president of the Harrison County Medical Society in 1938 and became an honorary life member of that Society, the West Virginia State Medical Association and the American Medical Association in 1943.

Doctor Ladwig has engaged actively in many civic and community affairs. His most vital interest is the work of his church. He still is a member of the Official Board and a Trustee of the First Methodist Church of Clarksburg and has served for more than a decade as chaplain to the Harrison County Medical Society.

He is married to the former Calora Hardway of Lost Creek. They have one daughter, Margaret Cornelia Ladwig, who is in charge of the Placement Advisors Office at West Virginia University.

State Physicians Named ACOG Fellows

Five state physicians were inducted as Fellows of the American College of Obstetricians and Gynecologists during the annual clinical meeting of the ACOG which was held at the Americana Hotel in Bal Harbour, Florida, May 17-22.

The new Fellows are Drs. John H. Sproles of Bluefield; Daniel A. Mairs of Charleston; Dean R. Goplerud of Morgantown; and John Battaglino, Jr., and Fernando G. Giustini, both of Wheeling.

Dr. R. Alan Fawcett New President Of W. Va. Acad., Oph. & Otol.

Dr. R. Alan Fawcett of Wheeling was installed as president of the West Virginia Academy of Ophthalmology and Otolaryngology during the 17th annual meeting of that organization at The Greenbrier in White Sulphur Springs, April 15-18. He succeeds Dr. James T. Spencer of Charleston.

Other new officers are as follows:

Dr. Ralph W. Ryan, Morgantown, president elect; Dr. Worthy W. McKinney, Beckley, secretary-treasurer; and Dr. J. E. Blaydes, Jr., of Bluefield, assistant secretary-treasurer.

Drs. William C. Morgan, Jr., and Alfred J. Magee, both of Charleston, and Edward Shupala of Parkersburg, were named directors and members of the Executive Committee which also includes the three immediate past presidents, Drs. James T. Spencer of Charleston and William K. Marple and Albert C. Esposito, both of Huntington.

The scientific program included papers presented by the following guest speakers:

Drs. Alston Callahan of Birmingham, Alabama; Trygve Gunderson of Boston; John W. Henderson of Rochester, Minnesota; James W. Cole of Danville, Pennsylvania; Richard Farrior of Tampa, Florida; and Harold G. Tabb of New Orleans.

Make Your Reservation Now!

Members of the West Virginia State Medical Association are urged to make reservations without delay for accommodations during the 97th Annual Meeting at The Greenbrier in White Sulphur Springs, August 20-22, 1964. Application forms for room reservations were enclosed in a bulletin mailed recently to each member. The completed forms should be mailed directly to the Reservation Manager, The Greenbrier, White Sulphur Springs, West Virginia.

Speakers at the annual meeting of the West Virginia Academy of Ophthalmology and Otolaryngology at The Greenbrier included, left to right, Drs. James W. Cole of Danville, Pennsylvania; Harold G. Tabb, Professor and Chairman, Department of Otolaryngology, Tulane University School of Medicine, New Orleans; and Alston Callahan of Birmingham, Alabama.

W. Va. Radiological Society Meeting Held in Martinsburg

A meeting of the West Virginia Radiological Society was held in Martinsburg, April 18-19, and it marked the first time the Society had met in the Eastern Panhandle since its organization.

Dr. D. Ewell Hendricks, second vice president of the Eastern Panhandle Medical Society, welcomed the visiting physicians at a dinner which was held on Saturday evening, April 18.

Dr. Harold I. Amory of Morgantown, president of the Radiological Society, introduced the speaker, Dr. C. H. Joseph Chang, also of Morgantown, who presented a paper on "Mammography."

The members met at King's Daughters' Hospital on Sunday morning for a discussion on unusual and interesting cases. A business meeting was held at the conclusion of the scientific session.

New officers of the West Virginia Academy of Ophthalmology and Otolaryngology are shown following their election at the annual meeting at The Greenbrier. Left to right, Drs. James T. Spencer of Charleston, immediate past president; Ralph W. Ryan of Morgantown, president elect; William C. Morgan, Jr., of Charleston, director; R. Alan Fawcett of Wheeling, president; J. E. Blaydes, Jr., of Bluefield, assistant secretary-treasurer; and Worthy W. McKinney of Beckley, secretary-treasurer.

Dr. Hu C. Myers New President Of W. Va. Chapter, ACS

Dr. Hu C. Myers of Philippi was installed as president of the West Virginia Chapter of the American College of Surgeons during the annual meeting of that organization which was held at The Greenbrier in White Sulphur Springs, April 16-18. He succeeds Dr. Jack C. Morgan of Fairmont.

Dr. E. F. Heiskell, Jr. of Morgantown was elected vice president and Dr. Theodore P. Mantz of Charleston, secretary-treasurer.

Dr. Charles M. Scott of Bluefield, a past president, was reelected Governor of the West Virginia Chapter, ACS, and Doctor Morgan and Dr. Victor S. Skaff of Charleston, councilors.

Dr. James H. Spencer of Chicago, Assistant Director of the American College of Surgeons, was a guest during the meeting and presented a summary of ACS activities and a progress report on its new building in Chicago.

The out-of-state speakers on the scientific program were Dr. George H. Yeager, Clinical Professor of Surgery, University of Maryland School of Medicine; Dr. Kenneth W. Warren, Lahey Clinic, Boston; and Dr. Robert W. Buxton, Professor of Surgery, University of Maryland School of Medicine.

Members of the West Virginia University School of Medicine faculty appearing on the three-day program included Drs. Richard A. Currie, Alvin L. Watne, Herbert Warden, D. Franklin Milam, Walter H. Moran, Jr., Norman W. B. Craythorne and Bernard Zimmermann, Professor and Chairman of the Department of Surgery.

Cash prizes were awarded for the two best papers presented by residents in West Virginia hospitals. Dr. Thomas J. Tarnay, chief resident in surgery at the West Virginia University Hospital, received first prize of $100 for his paper on "The Isolated Annulus: A Method for the Evaluation of Intra-Cardiac Prosthetic Thrombosis."

Dr. Kenneth E. Thomas, also a resident at the WVU Hospital, received a $50 prize for a paper on "Scalene Lymph Node Biopsy."

10th Annual Cabell County Symposium In Huntington on September 10

The Cabell County Medical Society's 10th Annual Symposium on "Pulmonary Disease" will be held at the Frederick Hotel in Huntington on September 10.

Speakers participating in the program will be as follows:

Alvin L. Barach, M. D., of New York City, Clinical Professor of Medicine, Columbia University College of Physicians and Surgeons.

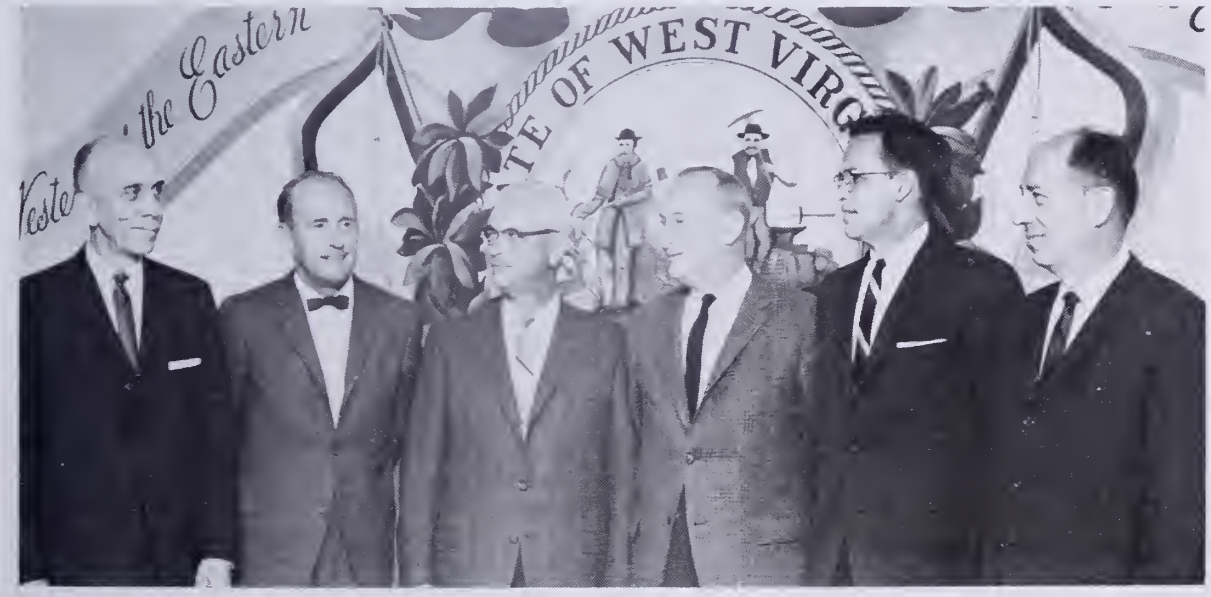
Richard H. Overholt, M. D., of Boston, Clinical Professor of Surgery, Tufts University School of Medicine and Director of Overholt Thoracic Clinic, Boston.

Max Littman, M. D., New York City, Associate Professor of Medicine, New York University School of Medicine and Senior Research Scientist, New York City Department of Health.

Roy R. Greening, M. D., Philadelphia, Professor of Radiology, Jefferson Medical College, Philadelphia.

There will be no registration fee and additional information may be obtained by writing to the program chairman, Dr. Joseph M. Farrell, First Huntington National Bank Building, Huntington, W. Va.

The other members of the committee are Drs. Thomas Francis Scott, Albert C. Esposito, Thomas J. Conaty, James P. Carey, Dennis S. O'Connor, G. G. Hunter and M. Lawrence White, Jr.

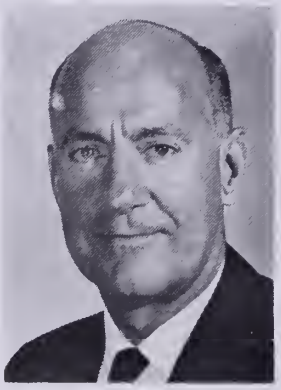


New officers of the West Virginia Chapter, American College of Surgeons, are shown following their election at the annual meeting of the Chapter at The Greenbrier, April 16-18. Left to right: Dr. Hu C. Myers of Philippi, president; Dr. E. F. Heiskell, Jr., of Morgantown, vice president; Dr. Theodore P. Mantz of Charleston, secretary-treasurer; Dr. Charles M. Scott of Bluefield, governor; Dr. Jack C. Morgan of Fairmont, immediate past president; and Dr. Victor S. Skaff of Charleston, councilor.

Large Attendance Expected at AMA Meeting in San Francisco

More than 15,000 physicians are expected to attend the 113th Annual Convention of the American Medical Association in San Francisco, June 21-25. The Woman's Auxiliary to the AMA will hold its 40th annual meeting during the same week.

General headquarters for the meeting will be the Fairmont Hotel, where the House of Delegates will meet



Edward R. Annis, M. D.

Norman A. Welch, M. D.

throughout the week. Scientific sessions will be held in the Civic Auditorium and in other nearby auditoriums. Industrial and scientific exhibits will be housed in the Auditorium.

Dr. Edward R. Annis of Miami, Florida, President of the AMA, will preside at the meeting and will deliver addresses before the House of Delegates and the Auxiliary. He also will participate in inaugural ceremonies for Dr. Norman A. Welch of Boston, who will succeed him as president.

State Delegates to Attend Meeting

Drs. Frank J. Holroyd of Princeton and Charles A. Hoffman of Huntington will represent the West Virginia State Medical Association as delegates to the meeting. The alternate delegates are Drs. Thomas G. Reed of Charleston and D. E. Greeneltch of Wheeling.

Dr. I. E. Buff of Charleston once again will serve as a member of a committee which will offer a medical checkup to physicians attending the meeting.

'The Patient as a Person'

One of the features of the meeting will be a program on Medicine and Religion entitled "The Patient as a Person," which will be held on Sunday evening, June 21.

The principal speakers will be Dr. William C. Menninger of Topeka, Kansas, and Rabbi Abraham J. Heschel, Jewish Theological Seminary, New York City.

Scientific Sessions

High pressure oxygen chambers, computors and organ transplantation will be among the subjects which will be discussed at the scientific sessions.

The medical use of hyperbaric oxygenation and computors will be the subject of half-day general scientific sessions while 18 papers on transplantation will be presented during the Fourth Multiple Discipline Research Forum.

The transplantation program will include research on human kidney graphs, canine lung and canine heart transplants and various means of preventing rejection of grafted organs. The moderators for the two-part program will be Drs. John P. Merrill of Boston and James D. Hardy of Jackson, Mississippi.

The complete program of the AMA Convention may be found in the May 11 issue of *The JAMA*.

Mrs. Thomas L. Harris Honored By Alderson-Broaddus College

Mrs. Thomas L. Harris of Parkersburg was awarded an honorary Doctor of Humane Letters degree by Alderson-Broaddus College during commencement exercises held at Philippi on June 1.

Mrs. Harris is the wife of Dr. Thomas L. Harris of Parkersburg, a past president of the West Virginia State Medical Association.

She has received a number of awards for community service and was the only woman honored by the city of Parkersburg during the 1963 West Virginia Centennial observance.

The meritorious civic service of Mrs. Harris has been recognized by such groups as the Parkersburg Chamber of Commerce which said:

"Her generosity with her time and great talent has meant so much to many other organizations in our community. She has assisted churches, regardless of denomination. She has been active in encouraging the social activities of young people. Her work in hospitals has been unstinting and her wise counsel and enthusiastic support of community planning has been of great service."

Mrs. Harris recently contributed heavily in time, service and money to establish the Boys Club in Parkersburg to enhance the city's overall recreational program.

Alderson-Broaddus also awarded honorary degrees to the Honorable Llewellyn E. Thompson, Ambassador-at-Large with the U. S. State Department, and the Rev. J. William Bonner, pastor of the Baptist Temple in Fairmont.

Medical Meetings, 1964

The following is a partial list of national, state and district medical meetings scheduled for 1964:

June 18—B-R-T Postgraduate Session, Elkins
June 21-25—AMA Annual Meeting, San Francisco.
June 25—Preston Co. Summer Session, Kingwood.
Aug. 20-22—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 4—W. Va. Heart Assn., Huntington.
Sept. 10—Cabell County Symposium, Huntington.
Oct. 1—Rural Health Conf., Jackson's Mill.
Oct. 11-15—ACCP Congress, Mexico City.
Oct. 23-25—Potomac-Shenandoah Valley PG Institute, Martinsburg.
Oct. 23-25—American Heart Assn., Atlantic City.
Nov. 16-19—Southern Medical, Memphis, Tenn.
Nov. 29-Dec. 2—AMA Clinical Meeting, Miami Beach.

Failure to Report Venereal Disease Hampers Control Measures

Less than one-fourth of the infectious syphilis and gonorrhea cases in West Virginia in 1962 were reported to the State Department of Health.

A survey made by the American Social Health Association showed that West Virginia had 453 cases of infectious syphilis in 1962, of which only 51, or 11.3 per cent, were reported to the Department of Health. The gonorrhea cases totaled 5,919 cases with 1,003 reported.

State Director of Health Dr. N. H. Dyer, writing in his weekly State of the State's Health, reported that the cluster testing method of casefinding is utilized by that agency. Investigators interview the patient, to get not only the names of contacts but also suspects and associates who may have been exposed to the infection and may need treatment. If a single infectious case goes untreated, it is almost certain to start a new chain of infection.

National Pool Created

In a recent report the New York Academy of Medicine said poor reporting to health authorities has created a national pool of two to three million cases of infectious syphilis and gonorrhea suspects who are unknown.

During the past two years, considerable headway has been made in reporting by private laboratories in West Virginia. Doctor Dyer noted that 93.6 per cent of these facilities presently are participating in the program for reporting positive specimens to the state agency.

He pointed out that only one case can trigger an epidemic and so long as there is a breakdown in the reporting process from laboratories or physicians—or in our own efforts to include every possible contact in the investigation—control of venereal disease is doomed to failure.

From 1947 until 1957 the number of syphilis cases in the nation dropped from 106,539 to an all-time low of 6,251. Since then the figure has grown slowly to 22,045 cases reported in 1963, more than three times the number for 1957. The cases reported are but a fraction of the total.

In 1957—the year syphilis hit its lowest ebb in the nation—a total of 1,300 cases of all types was reported. In 1963, when the national incidence increased by more than 250 per cent, only 1,193 cases were reported.

During the same period, primary and secondary syphilis increased 139.4 per cent in West Virginia. In 1963, exactly a third of these cases were among teen-agers.

ACCP Congress in Mexico City

Physicians from more than 50 countries will present papers and discuss recent advances in cardiovascular and pulmonary diseases at the VIII International Congress on Diseases of the Chest in Mexico City, October 11-15. Further information may be obtained by writing to the American College of Chest Physicians, 112 East Chestnut Street, Chicago, Illinois, 60611.

AMA Woman's Auxiliary To Meet In San Francisco, June 21-24

The 41st Annual Convention of the Woman's Auxiliary to the American Medical Association will be held at the St. Francis Hotel in San Francisco, June 21-24.

Mrs. Pat A. Tuckwiller

Mrs. Pat A. Tuckwiller of Charleston, President of the Woman's Auxiliary to the West Virginia State Medical Association, will head the State delegation. More than 3,000 wives of physicians are expected to attend the meeting which will be held in conjunction with the Annual Meeting of the AMA.

A tea and fashion show honoring the president and president elect will be held on Sunday afternoon, June 21, and the convention will be convened formally on Monday morning, June 22, with reports of officers and chairmen of the various committees.

The second general session will be held on Tuesday morning and the annual luncheon honoring national past-presidents will be held that same day. The speakers will be Dr. Edward R. Annis, AMA President, and the Auxiliary at this time will announce its annual contribution to the AMA-ERF.

Mrs. C. Rodney Stoltz of Watertown, South Dakota, the president, will preside at the meeting. Mrs. William H. Evans of Youngstown, Ohio, the president elect, will be installed as president at the third general session on Wednesday morning.

New national officers and committee chairmen will be introduced at a post convention conference on Thursday morning. Dr. Ernest B. Howard, Assistant Executive Vice President of the AMA, will discuss principal actions of the AMA House of Delegates.

Dr. Charles A. Hoffman Participates In AMA Regional Meeting

Dr. Charles A. Hoffman of Huntington served as moderator of a panel discussion at the Southeastern Regional Conference on Health Insurance and Prepayment which was held at the Riviera Motor Hotel in Atlanta, Georgia, April 18-19.

The theme of the two-day meeting was "Health Service Protection Today" and it was sponsored by the AMA Council on Medical Service and the Committee on Insurance and Prepayment Plans.

Doctor Hoffman, who is a member of the AMA Committee on Insurance and Prepayment Plans, was the moderator of a panel discussion on "Evaluation of Health Service Coverage."

Doctor Hoffman also was notified early in May of his appointment as a member of the Professional Service Index Committee of the National Association of Blue Shield Plans.

Duties of County Coroners Assigned By The Commission on Postmortem Examinations

EFFECTIVE July 1, 1963, the Legislature of West Virginia repealed Article 12, Chapter 61 of the Code of West Virginia, one thousand nine hundred thirty-one, as amended, and in accordance with the new Article 12, Section 14, it shall be the duty of the County Courts of every county from time to time to appoint a coroner for such county who shall hold his office during the pleasure of such court, and shall take the oath of office prescribed for any other county officer. The county coroner shall, hereafter, perform such duties as may be assigned to him under the rules and regulations promulgated by the Commission on Postmortem Examinations. Therefore, under the authority of the above mentioned Article 12, Section 14 of the Official Code of West Virginia, the Commission on Postmortem Examinations hereby outlines the duties of county coroners:

A. Deaths To Be Reported To County Coroners

(1) When any person shall die in this State from:
- (a) Violence
- (b) Apparent suicide
- (c) Suddenly, when in apparent good health
- (d) Suddenly, when unattended by a physician
- (e) When an inmate of a public institution not hospitalized therein for organic disease
- (f) Some disease which might constitute a threat to public health
- (g) Any suspicious, unusual or unnatural manner

The coroner of the county in which such death occurs shall be immediately notified by the physician in attendance, by any law enforcement officer having knowledge of such death, or by the funeral director, or by any other person present.

Any physician or law enforcement officer, funeral director or embalmer who wilfully fails to comply with this section shall be guilty of a misdemeanor, and upon conviction, shall be fined not less than fifty dollars nor more than five hundred dollars.

Upon receipt of such notice, the coroner shall take charge of the dead body, make inquiries regarding the cause and manner of death, reduce his findings to writing, and promptly make a full report thereof on forms prescribed for such purpose, retaining one copy of such report for his own office records, and should deliver another copy thereof to the prosecuting attorney of such county and to any attorney of record in any criminal proceedings or civil action wherein the cause of death is an issue. The coroner may administer oaths and affirmations, and take affidavits and make examinations as to any matter within the jurisdiction of his office. The coroner shall take possession of any objects or articles which, in his opinion, may be useful in establishing the cause of death, and deliver them to the prosecuting attorney of such county.

If, in the opinion of the coroner of the county in which the death in question occurred, it is advisable and in the public interest that an autopsy be made, it shall be the duty of the coroner to call this to the attention of the prosecuting attorney of the county, and if the prosecuting attorney deems it necessary, he may order an autopsy performed on the dead body by a qualified pathologist. A full record and report of the findings developed by the autopsy shall be filed with the coroner and prosecuting attorney by such person making the autopsy.

The office of coroner shall keep full, complete and properly indexed records of all deaths investigated, containing all relevant information concerning the death, and the autopsy report, if such be made. Any prosecuting attorney or law enforcement officer may secure copies of such records or information necessary to him for the performance of his official duties. Copies of such records or information shall be furnished, upon request, to any party to whom the cause of death is a material issue. Any person performing an autopsy pursuant to the authority of this section shall be empowered to keep and retain, for and on behalf of the coroner, any tissue from the body upon which the autopsy was performed which may be necessary for further study or consideration.

A coroner shall turn over and deliver to his successor in office all of the papers, reports and records of his said office.

The coroner shall not send, or cause to be sent, to any funeral director, undertaker, mortician or embalmer, the body of any deceased person without having first made due inquiry as to the desires of the next of kin, or any persons who may be chargeable with the funeral expenses of such deceased person; and if any such kin or person can be found, his authority and direction shall be received as to the disposal of said corpse.

It shall be the duty of every county coroner in those deaths that occur where the prosecuting attorney does not order an autopsy to be performed on the deceased, but in the interest of establishing a cause of death to differentiate between natural causes and accidental death where it is advisable in cases pertaining to compensation claims, insurance benefits, possible future-liable claims, etc., the coroner will call this to the attention to the next of kin, or any person who may be chargeable with the funeral expenses of such deceased person so that they can make arrangements for the autopsy, and if they desire to have an autopsy performed, the coroner shall secure permission on a form "Request for Autopsy."

In the event an autopsy on a deceased person is performed that has been ordered by the next of kin, or any person who may be chargeable with the funeral expenses, the person performing said autopsy shall furnish the coroner with a copy of his findings and cause of death and the coroner shall not certify to

the cause of death on the death certificate until he knows the results of the autopsy.

It shall be the duty of every county coroner to complete a death certificate on each death that comes under his jurisdiction in accordance with the rules and regulations of the West Virginia Department of Vital Statistics and use Publication No. 593, Public Health Service, U. S. Department of Health, Education and Welfare as a guide in completing the certificate.

When it becomes necessary because of illness, absence, need for personal interest, the coroner may appoint another qualified person in the county in which a death is to be investigated to act as Assistant Coroner for such county.

Auxiliary Officers Attend Board Meeting in Charleston

The annual Spring Meeting of the Executive Board of the Woman's Auxiliary to the West Virginia State Medical Association was held at the Daniel Boone Hotel in Charleston, April 28-29.

Mrs. Pat A. Tuckwiller of Charleston, the president, presided at the business session which was attended by 25 state officers, standing committee chairmen and county presidents and presidents elect.

Reports were presented by Mrs. Wilson P. Smith of Huntington; Mrs. James T. Spencer of Charleston; Mrs. Harry E. Beard of Huntington; Mrs. Clark K. Sleeth of Morgantown; and Mrs. J. A. B. Holt and Mrs. A. B. Curry Ellison, both of Charleston.

Dr. and Mrs. A. C. Chandler of Charleston were the guest speakers at the dinner meeting on Tuesday evening. They presented a most interesting commentary on their month's stay in Ecuador as part of the "People-to-People" program abroad the S. S. Hope.

Other dinner guests included Drs. William B. Rossman and Pat A. Tuckwiller of Charleston, members of the Auxiliary's Advisory Board, and Mr. Jerry Gould of Charleston, Executive Assistant of the State Medical Association. Mrs. Joseph A. Smith of Dunbar, president of the Woman's Auxiliary to the Kanawha Medical Society, was in charge of arrangements.

Mrs. George A. Curry of Morgantown, president elect, conducted a workshop on Wednesday morning with 32 in attendance.

Mrs. Pat A. Tuckwiller of Charleston, left, President of the Woman's Auxiliary to the State Medical Association, presided at the opening session of the annual Spring Meeting of the Executive Board in Charleston, April 28-29. Shown with her are Mrs. George A. Curry of Morgantown, President Elect, and Mrs. John W. Hash of Charleston, Parliamentarian.

Mrs. William R. Rice of Dunbar, program chairman, urged county officers to work closely with their program chairmen and moderated a panel in which emphasis was placed on increasing the Auxiliary's membership.

Mrs. John W. Hash of Charleston, secretary-treasurer of the West Virginia Medical Political Action Committee (WESPAC), gave a brief resume of the organization's activities and goals.

Other speakers included Mrs. L. Dale Simmons of Clarksburg; Mrs. Ray M. Kessel of Logan; Mrs. Rupert W. Powell of Fairmont; Mrs. A. C. Chandler of Charleston; and Mrs. Lynwood D. Zinn of Clarksburg.

Dr. and Mrs. Charles L. Goodhand of Parkersburg were guests at the 46th Annual Meeting of the American Radium Society at The Greenbrier in White Sulphur Springs, April 13-16. Doctor Goodhand, President of the State Medical Association, welcomed the delegates to West Virginia at the opening scientific session on Monday, April 13. The Goodhands are shown above at the Society's Annual Banquet. Those at the table are, left to right, Mrs. Ralph T. Ogden of Hartford, Connecticut, Doctor Goodhand, Mrs. Wendell C. Hall of Hartford, Doctor Ogden, Mrs. H. Peter Mueller of Belmont, Massachusetts, Doctor Hall, Mrs. Goodhand, and Doctor Mueller.

Spring Meeting of Council Held In Charleston on May 3

The regular Spring meeting of the Council of the West Virginia State Medical Association was held at the Daniel Boone Hotel in Charleston on Sunday, May 3, 1964, with the Chairman, Dr. L. J. Pace of Princeton, presiding.

Dr. O. W. Ladwig of Wilsonburg, Harrison County, was selected during the meeting as the State Medical Association's 1964 "General Practitioner of the Year."

He will receive the award officially at the second session of the House of Delegates during the annual meeting at The Greenbrier.

Election of Honorary Members

The following physicians were elected to honorary life membership in the West Virginia State Medical Association:

Society	*Physician*	*Address*
Boone	John A. McCraw	Van
Cabell	Walter C. Swann	Huntington
Kanawha	C. R. Kessel	Ripley
Marion	Guy R. Post	Fairmont
McDowell	James H. Anderson	Hemphill
McDowell	Noel F. Coulon	Bluefield
McDowell	John E. Davis	Welch
McDowell	W. Branch Young	Northfork

'Medical Education and General Practice'

Dr. Charles L. Goodhand of Parkersburg, the President, reported receipt of a letter from Dr. Kinloch Nelson, Dean of the Medical College of Virginia, concerning the possibility of arranging a meeting later this year to discuss "Medical Education and General Practice."

Doctor Goodhand said that representatives of various medical schools and organizations in West Virginia, Virginia and North Carolina would be invited to attend the meeting. He said that discussion would be centered around the subject of medical schools and general practice.

The Council went on record as approving the proposed meeting and requested Doctor Goodhand to inform Dean Nelson that the Association would be interested in sending representatives to attend the meeting.

Mandatory Licensure for Registered Nurses

Miss Juliann Ritter, Executive Director of the West Virginia Nurses Association, and Miss Frances M. McKenna, Executive Secretary of the West Virginia State Board of Examiners for Nurses, appeared before the Council to discuss a mandatory licensure bill which the Nurses Association plans to introduce during the 1965 session of the State Legislature.

Following discussion, the matter was referred to the Nurses Liaison Committee for study. It was suggested that the Chairman of the Committee be requested to ask the Nurses Association and other interested groups to meet for the purpose of discussing possible revisions in the bill.

Report of Medical Economics Committee

Dr. George R. Callender, Jr., of Charleston, Chairman of the Medical Economics Committee, presented a detailed report concerning various activities under study by the Committee.

He said that reports of several projects undertaken during the past year by the Committee should be completed in time for submission to the Council at the meeting in August.

Dr. Harry S. Weeks, Jr., of Wheeling, Chairman of the Joint Conference Committee, reported that this group had met on several occasions during the past few months with Mr. W. Bernard Smith, Commissioner of the Department of Welfare.

Doctor Weeks said it was hoped that the Department would adopt several recommendations made by the Committee to improve the medical programs. He also requested members of the Council to urge that problems relating to these programs be handled on the local level whenever possible.

Commission on Postmortem Examinations

Dr. Richard W. Corbitt of Parkersburg, Chairman of the Commission on Postmortem Examinations, discussed activities of the Commission which was established by the State Legislature in 1963.

He explained that the Legislature failed to appropriate funds for the operation of the Commission and therefore it had not been possible to employ a chief medical examiner.

He said there had been considerable discussion concerning the duties of county coroners since passage of the legislation. He explained that a letter had been mailed recently to county courts outlining the temporary duties assigned to coroners (See page 170).

The meeting was attended by Dr. L. J. Pace of Princeton, Chairman; Dr. Charles L. Goodhand, Parkersburg, President; Dr. Albert C. Esposito, Huntington, President Elect; Dr. Seigle W. Parks, Fairmont, Vice President; Dr. D. E. Greeneltch, Wheeling, Councilor-at-Large; and Drs. Joseph L. Curry, Wheeling; Maynard P. Pride, Morgantown; Richard V. Lynch, Jr., Clarksburg; Buford W. McNeer, Hinton; Richard W. Corbitt, Parkersburg; William B. Rossman, Charleston; D. Alene Blake, Oak Hill; and Mr. William H. Lively, Secretary ex-officio, and Mr. Jerry Gould, Executive Assistant, both of Charleston.

The meeting was also attended by Dr. Frank J. Holroyd, Princeton, and Dr. Charles A. Hoffman, Huntington, AMA Delegates; Dr. Thomas G. Reed, Charleston, AMA Altenate; Dr. George F. Evans, Clarksburg, Editor of *The Journal*; Dr. James S. Klumpp, Huntington, Parliamentarian; Dr. N. H. Dyer, Charleston, Director of the State Department of Health; Dr. George R. Callender, Jr., Charleston, Chairman of the Medical Economics Committee; Dr. Harry S. Weeks, Jr., Wheeling, Chairman of the Joint Conference Committee; Miss Juliann Ritter, Charleston, Executive Director of the West Virginia Nurses Association; Miss Frances M. McKenna, Charleston, Executive Secretary of the West Virginia State Board of Examiners for Registered Nurses; Dr. E. Lyle Gage, of Bluefield, Past President; and Dr. Ralph H. Nestmann, Charleston.

The West Virginia Medical Journal

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Pleural Mesothelioma

(Report of Two Cases: One Benign and One Malignant)

Victor M. Napoli, M. D.

In the recent medical literature, mesothelioma, or primary tumor derived from the cells lining serous membranes such as pleura, pericardium and peritoneum, has gained general acceptance as a definite pathological entity. In earlier publications some authors[1, 2] expressed serious doubt as to the existence of primary mesothelial tumor. They contended that the reported cases of malignant pleural mesothelioma were metastatic lesions from primary neoplasms not revealed by clinical means nor at autopsy. Following the basic contributions of Stout and Murray,[3] however, who demonstrated by tissue culture methods the mesothelial origin of these tumors, increasing numbers of pathologically proven mesothelioma have been reported. Two types have been recognized: the localized, usually benign variant, and the diffuse, spreading malignant form. Large series of localized tumors were reported by Clagett[4] and Foster and Ackermann.[5] It has been stated that localized or solitary mesothelioma is seen and diagnosed with sufficient frequency to assume clinical significance in the differential diagnosis of thoracic tumors.[6] The other variety of pleural mesothelioma, the malignant and spreading type, has been reviewed in comprehensive necropsy studies by Godwin,[7] McCaughey,[8] and Manguikian and Prior.[9]

The acquired knowledge of the natural history of this tumor has resulted in improved clinical management in these cases. Surgical removal of localized primary pleural tumors has been successful in large series of cases.[4, 5] The diffuse, malignant variety remains a disease with a fatal prognosis, although prolongation of life is possible with intrapleural injection of radioactive gold.[10]

Submitted to the Publication Committee, December 5, 1963.

The Author

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According to the description given by most observers, the localized pleural mesothelioma is a slow growing, circumscribed, often encapsulated mass that may be attached to the pleura by a pedicle and is easily removed at thoracotomy. The tumor also may develop subpleurally or within the lung tissue as in 10 of the 18 cases reported by Foster and Ackermann,[5] but it still is localized and surgically resectable. On the other hand, a tendency to spread diffusely over the pleural surface encasing and surrounding the lung with little or no invasion of the underlying pulmonary parenchyma is characteristic of the diffuse, malignant mesothelioma. Extension by continuity to adjacent structures may occur in diffuse mesothelioma, most frequently to the pericardium, with a resulting frozen hemithorax. Blood-borne metastases have been infrequent in the experience of most observers. Walcott[11] found no distant metastases in six cases. Scalene node biopsy was negative in all five cases of malignant mesothelioma reported by Manguikian and Prior.[9] Hochberg[12] expressed the opinion that the solitary localized form may become diffuse, but no mention of such possibility is noted in more recent literature. Recurrence of localized tumors occurred in 4 of 24 cases reported by Clagett[4] but in none of the 18 cases of the series of Foster and Ackermann.[5]

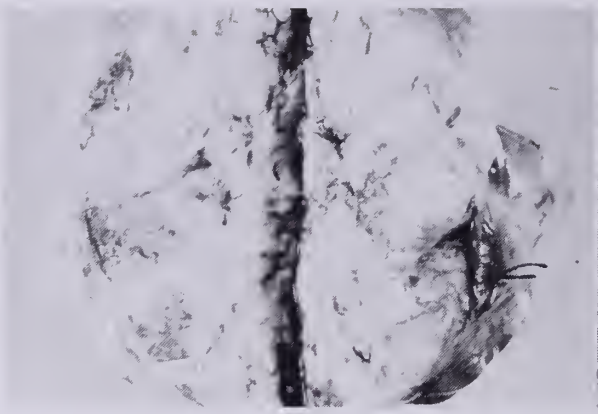

Figure 1

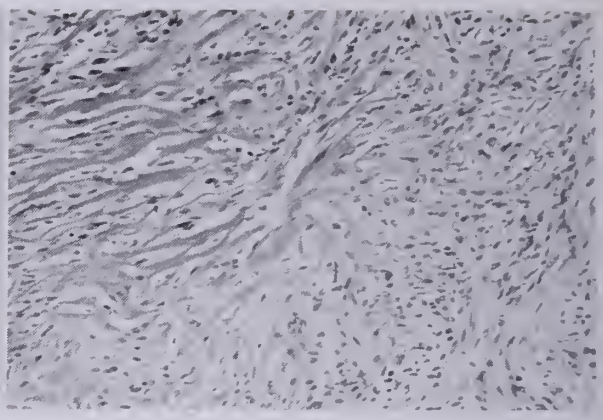

Figure 2

Figure 1. Cut surface of localized benign pleural mesothelioma showing a whorled fibrous appearance. Figure 2. Histologic architecture of localized, benign mesothelioma of the fibrous type.

Microscopic Pattern

The microscopic patterns presented by mesothelioma are rather varied. The localized type has been classified on histologic grounds as fibrous, tubular, papillary or mixed.[13] A combination of epithelium-like tubular or papillary structures with sarcomatous areas is most frequently demonstrated in diffuse pleural mesothelioma, and is considered to be important for the histologic diagnosis by Campbell.[14] The varied cytoarchitecture seen in these neoplasms can be explained on the basis of the embryologic development of the pleura. The mesothelium, which is a derivative of the multipotential epithelial mesoderm, retains a degree of versatility during postnatal life, and is capable of differentiating into fibroblasts in tissue culture as indicated by older experiments of Maximow.[15]

Mesothelial tumor of sarcomatous type can grow in tissue culture either as an epithelium-like (mesothelial) tissue or as a fibroblastic tissue, depending on the medium used. This experimental finding of Stout and Murray,[3] later confirmed by Sano,[16] helped explain how tumors of mesothelial origin either can be epithelium-like or fibroblastic, or both.

Hyaluronic acid can be formed by mesothelial cells in tissue cultures. Measureable amounts of this substance were found in the ascitic fluid in a case of malignant mesothelioma of the peritoneum reported by Dvoskin.[17]

The association of low blood sugar levels, often causing convulsions or coma, with localized neoplasms variously classified as mesothelioma, mesodermal tumor, or fibrogenic tumor, has been known for some time. In 1961, Rogers and Houseworth[18] reviewed the literature on the subject and found 25 published cases of hypoglycemia associated with large extrapancreatic tumor, interpreted as mesothelioma. All were encapsulated or well circumscribed and eight were intrathoracic. Other syndromes described in cases of mesothelioma include cryoglobulinemia[19] and nephrosis.[20] The frequent coexistence of asbestosis and malignant pleural mesothelioma has been noted by Wagner.[21] This author, however, warns that the pathologic evidence for associating these tumors with asbestos exposure is not conclusive.

The two cases reported in this paper, one of localized benign mesothelioma and one of the diffuse malignant variety, represent further contribution to the literature on the subject. Microscopic examination of the benign mesothelioma revealed features of some interest in relation to the symptomatology presented by the patient.

Case 1.—Mrs. S. G., a 50-year-old white woman developed fever, chest pain and cough productive of scant sputum in July, 1960. The symptoms lasted a few weeks and subsided, apparently following antibiotic therapy. One year later (July, 1961), the patient developed a second episode of chills, fever, cough and nonspecific chest pain which lasted only a few days. In June, 1962, four weeks prior to admission to WVU Hospital, she again experienced chills and fever with concomitant frequency and dysuria. The urinary symptoms responded to treatment with sulfonamides. The patient, however, started having pain in the knees and tibias. After a brief stay in another hospital, she was referred to WVU on July 22, 1962.

Positive findings on admission consisted of dullness, decrease in breath sounds and tactile fremitus over the right posterolateral hemithorax. Fingers and toes showed clubbing. On chest x-ray a mass was seen in the region of the right pulmonary base, and pulmonary osteoarthropathy was demonstrated in x-ray films of the tibias. Serum proteins were 6.8 Gm. per cent;

albumin 2.6; globulin 4.2; serum alkaline phosphatase was 14.9 K.A.U. Other routine laboratory studies gave normal results.

A percutaneous Vim-Silvermann needle biopsy of the thoracic mass was performed on July 26, 1962, and yielded amorphous debris. On August 1, 1962, thoracotomy was performed. A large pedunculated mass attached to the visceral pleura of the right pulmonary base was easily removed at surgery. Postoperatively the patient did well. She was readmitted to WVU on September 23, 1962, for elective cholecystectomy. The pulmonary osteoarthropathy had markedly decreased, but still was present nine months after surgery.

Pathology.—The surgical specimen weighed 420 Gm., was roughly triangular, lobulated, firm to rubbery, and was covered with serosa. It measured 13 cm. in greatest dimension. Sections showed a whorled, white-yellow surface, generally firm, but with a few soft areas (Figure 1). Histologic examination revealed a tumor composed of elongate nuclei with ill-defined cytoplasm, supported by an abundant, partly hyalinized fibrous stroma (Figure 2). The cellularity was considerable in a few areas, most often at the periphery of the tumor but was scant in the central portions where extensive fibrosis was present. Foci of recent necrosis could be demonstrated (Figure 3). Adjacent or within these areas there were blood vessels containing thrombi. No papillary or tubular structures were seen, but there were large venous channels. Mitoses were exceptional and no anaplastic features were present. The pathologic diagnosis was "localized fibrous mesothelioma."

Case 2.—C. S., a 63-year-old white man, sustained multiple rib fractures in 1959 and since that time had complained of wheezing and pain in the right hemithorax. During the following two years progressive dyspnea and a weight loss of 30 pounds had occurred. Five thoracenteses were necessary in January and February, 1962, because of recurrent right pleural effusion.

At the time of the February admission, physical examination revealed decreased chest expansion and dullness to percussion over the right hemithorax. The liver was palpable. A slight degree of clubbing of the fingers was noted. Chest x-ray demonstrated complete opacification of the right lung field. Sedimentation rate was 40 mm. in one hour. WBC's were 15,450/cu. mm. Other laboratory tests gave normal results.

Shortly after admission 1500 cc's. of serosanguineous fluid was removed by thoracentesis. The sediment contained cells which were reported as

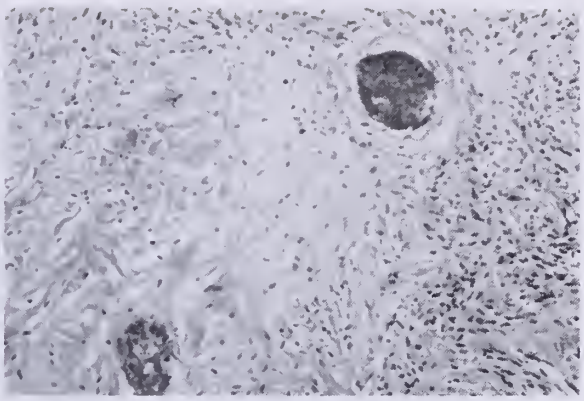

Figure 3. Infarcts in localized fibrous mesotheliomas.

highly suspicious for malignancy. Examination of a needle biopsy specimen from the tumor was not conclusive. The patient's condition deteriorated rapidly in the two weeks after admission. Fever, hyperazotemia and nodal tachycardia developed terminally. He expired on March 15, 1962.

Pathology.—At autopsy the main pathologic findings were confined to the right hemithorax. The right lung was atelectatic and completely surrounded by a layer of whitish-yellow firm tumor varying in thickness from 4 to 10 cm. (Figure 4). Numerous cavities measuring up to 9 cm. in diameter and filled with dark fluid were found within the tumor. The neoplasm extended into the interlobar fissures but did not grossly invade the pulmonary tissue. There also was extension of the tumor into the pericardium on the right side. No other changes were demonstrated in the right lung except atelectasis and congestion.

The left lung and the regional lymph nodes were normal on gross examination. Other pathologic findings included generalized atherosclerosis, mild cardiac hypertrophy and a chronic peptic ulcer of the stomach. In the liver there was severe chronic passive congestion and fatty metamorphosis. No evidence of distant metastasis or spread of the tumor outside the right hemithorax could be found.

Microscopically the tumor showed papillary and tubular areas as well as areas composed of elongate cells with sarcomatous appearance. The papillary structures were covered by epithelium-like cells with abundant, eosinophilic cytoplasm and hyperchromatic nuclei (Figure 5). Mitoses were present but were not numerous. Large tubular structures, often containing papillary or alveolar formations, could be seen. The transition from the papillary, epithelium-like areas to the sarcomatous areas was gradual. Intercellular collagen could be seen in the latter areas. Metas-

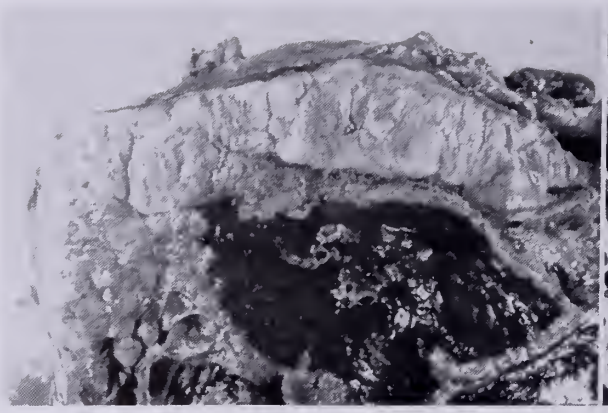

Figure 4

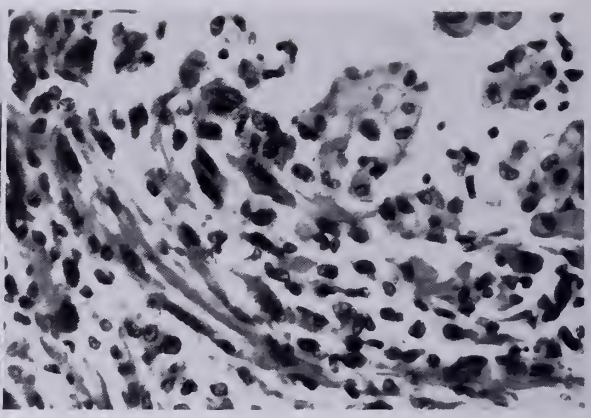

Figure 5

Figure 4. Malignant diffuse mesothelioma encasing atelectatic lung. Figure 5. Transition from papillary epithelium-like structures to fibrosarcomatous areas in malignant diffuse mesothelioma.

tatic tumor was found in one of the 8 mediastinal lymph nodes examined miscroscopically. Examination of many sections taken at the periphery of the tumor suggested that the neoplastic growth extended by continuity and by lymphatic permeation into the striated muscle of the diaphragm and the subpleural portions of the lung.

Discussion: Localized Pleural Mesothelioma

Repeated episodes of chills and fever of unknown origin, nonspecific chest pain and arthralgia had occurred in the first case of localized pleural mesothelioma. Association of these symptoms with the radiological evidence of osteoarthropathy and a circumscribed intrathoracic mass was highly suggestive of localized pleural mesothelioma, and the clinical diagnosis was entertained before surgery.

Symptoms and physical findings referable to the joints had been presented in 16 of 24 cases of localized pleural mesothelioma reported by Clagett.[4] Wiermann,[22] in a review of 1024 cases in which the patient underwent pleuropulmonary resection, found that arthralgia was much more frequent in cases of localized mesothelioma than in those of any other intrathoracic tumor. The osteoarthropathy due to intrathoracic neoplasm has been recently attributed to a reflex mechanism mediated through the vagus nerve. Afferent impulses arising in the lung are transmitted to the extremities where they result in increased blood flow and the development of clubbing and osteoarthropathy.[23] Dramatic resolution of the symptoms of osteoarthropathy followed removal of the tumor in three cases reported by Benoit and Ackermann.[6] In our case there was disappearance of arthralgia after surgery and considerable decrease of the bone changes which, however, still were detectable on x-ray after nine months. It is interesting to note that the pathologic examination of the localized mesothelioma demonstrated, in addition to wide fibrous areas, areas of recent necrosis and thrombosis of small vessels, with an overall histologic picture of recent infarcts.

The tumor received its vascular supply only through a small pedicle, and it is conceivable that the inadequate blood circulation was responsible for the necrosis. Necrosis was observed also in two of the cases reported by Foster and Ackermann[5] and "mucoid degeneration" was seen by Clagett[4] in some cases of pleural mesothelioma included in his series. Whether any relation exists between the necrosis and the episodes of chills and fever experienced by our patient with localized mesothelioma is speculative. Although fever is frequently associated with neoplastic diseases, occurring in approximately 50 per cent of cases, associated infection and not necrosis of tumor tissue accounts for the majority of these febrile manifestations, according to Browder.[24]

Discussion: Diffuse Malignant Mesothelioma

In Case 2, a conclusive diagnosis was established only at postmortem examination. The autopsy findings of a thick layer of tumor encasing the atelectatic right lung explained the opacity on x-ray of the involved hemithorax. As emphasized by Manguikian and Prior,[9] in diffuse mesothelioma of the pleura with progress of the disease, there is increasing opacification on x-ray with little or no change even after removal of large amounts of fluid. Rapid reaccumulation of bloody fluid was observed in each of the six cases of malignant mesothelioma reported by Walcott.[11] In our case, the sediment of the pleural effusion contained cells suspicious for malignancy and the histological examination of the small tumor fragment obtained by needle biopsy was suggestive but not diagnostic of malignant mesothelioma.

An open biopsy for the purpose of securing a more representative specimen was being considered when the patient's condition rapidly deteriorated and death occurred in the third week after hospitalization.

As observed at autopsy, the tumor was too far advanced for any form of palliation to be effective. In some cases, however, survival has been prolonged by intrapleural injection of radioactive gold.[10]

It is suggested that in suspected cases of malignant mesothelioma an effort be made to establish a tissue diagnosis during the early stages of the disease when palliative treatment can prolong the patient's life.

Summary

Two cases of mesothelioma of the pleura, one localized and benign, the other diffuse and malignant, are reported, along with surgical and autopsy observations.

Microscopic examination of the localized tumor showed infarcts. The possibility of relation of the infarcts to the chills and fever experienced by the patient is considered.

In the case of the malignant, diffuse mesothelioma, pathologic observations were characteristic.

Current literature on the subject is reviewed briefly.

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. . . the only deadly sin I know is cynicism.

HENRY STIMSON.

Etiological Factors in Acne*†

Robert S. English, M. D., and Joseph A. Witkowski, M. D.

THE clinical variants in acne readily suggest that the disease is a reaction pattern. Spontaneous remissions and unexplained exacerbations suggest that many etiologies are at play. Nevertheless, the pilosebaceous apparatus is always the target organ. The initial insult to this structure is obstruction followed by abscess formation.[1, 2, 3] This is true whether the offending agent is applied externally or is of internal origin. Here, however, we wish to divide acne into clinical variations and describe in detail the etiological factors present in adolescent acne. The following are variations of the acne complex divided on the basis of etiology and clinical appearance.

1. Acne vulgaris of adolescent acne.
2. Drug induced acne.
3. Hormone induced acne.
4. Tropical acne.
5. Chloracne.
6. Follicular occlusion or occlusion triad.[1]
7. Infantile acne.

In acne vulgaris as seen in the adolescent, three factors play a direct role: (1) androgenic hormones, (2) follicular plugging and (3) bacterial infection. Let us first consider the role of hormones in acne vulgaris. The androgenic fraction is responsible for sebaceous growth and development.[5] The facts which have guided us to this conclusion we will now elucidate. Acne usually begins at puberty coincident with the rise of urinary ketosteroids.[6] Androgens given orally to prepuberal children in low concentrations (physiological dosage) cause sebaceous gland enlargement.[5] Androgens applied to the skin of eunuchs will cause sebaceous gland enlargement. When the androgens are withdrawn from the eunuchs and prepuberal children, the sebaceous gland gradually returns to its original size.

Role of Estrogens

The role of estrogens in acne is not altogether clear. In pharmacological doses, however, they cause suppression of sebaceous gland growth and function. Minimal suppression of the sebaceous gland requires four times the physiological dose of estrogen. Maximal histological suppression can be obtained with approximately 2.5 mg. of ethinyl estradiol which is fifty times the replacement dose of estrogen. When, however, these individuals are placed on doses of estrogen sufficient to suppress sebum production, the androgens as measured by the urinary 17-ketosteroids remain unaltered.

Progesterone probably has no effect on acne, especially premenstrual acne. Strauss and Kligman[7] report finding acne and sebaceous gland enlargement in many young females one to two years prior to menarche. These observers[8] also were unable to show that natural progesterone in physiological amounts has any effect on size or output of the human sebaceous gland.

Follicular plugging plays an equally important role in acne. The earliest changes of the disease appear to be hyperkeratinization of the excretory duct of a sebaceous gland, resulting in deposition of the keratinous plug. With the exception of the beard area, the mature or terminal hair acts as a stylet which inhibits formation of the plug and keeps the follicular space clear of debris.[2] Fine lanugo hair is not strong enough to prevent plug formation. The presence of beard hair, however, does not spare the face from acne. The disease involves the beard area probably because the follicular neck of the pilosebaceous unit contains two distinct, separate channels; the hair shaft is one of the channels and the sebaceous gland with its excretory duct represents the other. Thus it is possible to have hair in the beard follicle and still to have a plug occur in the excretory duct of the sebaceous gland.

We believe antibiotics to have a positive effect in acne due to their antibacterial properties.[9] The specific bacteria in question is a gram posi-

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tive anaerobic diphtheroid which produces propionic acid from sebum. This bacteria has been termed the Propionibacterium, Corynebacterium acnes or the acne bacillus. Producing propionic acid from sebum probably is the only pathogenic role this bacteria plays in the human. If injected intravenously, it has no effect. Counteracting its inflammatory effect with corticosteroids remarkably reduces its pathogenicity. C. acnes does have certain characteristics which are worthy of mention. It is few in number before puberty and great in number thereafter. It mostly is present in those areas where the sebaceous gland is best developed; these are the V areas of the back and chest and of the neck and face. It has its greatest concentration in the sebaceous follicles and composes most of the plug in a comedo or whitehead. Interestingly, one can express literally millions of these bacteria in wormy extrusions from the side of the nose in adolescence.

Hormone Induced Acne.—It is a known fact that ACTH and glucocorticoids can provoke acneform lesions at all ages. This is more often seen in those individuals who are on large doses of corticosteroids over 3 to 4 weeks. This may be rationalized by the fact that corticosteroids can suppress the hair follicle into the resting phase since this is such a rapidly reproducing organ. Also corticosteroids may be interpreted in the body as an androgen. Masculinizing tumors such as those which involve the ovaries, adrenals, pineal gland and pituitary gland can be responsible for acneform lesions. One often can suspect a mechanism such as this when the acne lesions appear to be all in the same stage.

Drug Induced Acne.—Drug induced acne is a well known phenomenon characterized by acute acneform lesions occurring in those predisposed individuals after the ingestion of halogen-containing drugs. Clinically these lesions are distributed over the acne areas such as the face, neck, chest and back but also can involve the entire trunk and limbs. They are characterized by all appearing in the pustular stage. A gram stain of a smear from the lesions reveals no bacteria. Tridione used in petit mal epilepsy frequently has been reported as one such offender. Today no evidence has been found that this is allergic. Because it happens so infrequently and its mechanisms are unknown it is designated as an idiosyncratic reaction.[4]

Tropical Acne.—Tropical acne is a severe cystic type seen in warm, humid climates. Here the back and chest are affected and the face is spared. Certainly a contributing factor is sweating which causes maceration, therefore enhancing comedo formation. These individuals improve rapidly when they are removed from the humid environment.[4]

Chloracne or Occupational Acne.—This type occurs on the exposed areas in contact with chlorinated hydrocarbons, tars (naphthalenes, anthracene fractions), insoluble cutting oils, waxes and greases. This type of acne is clinically seen in machinists, oil filter refinery workers, roofers, electricians, chemists, tinsmiths, highway construction men and fishermen.[4] The primary lesion here again is the hyperkeratinization in the hair follicle which leads to plugging and then to abscess formation.[1]

Follicular Occlusion or Occlusion Triad.[4]—This includes acne conglobata which is a severe scarring and cystic type of acne. The second member of the triad is called dissecting cellulitis of the scalp and is characterized by multiple abscesses and sinus tracts involving a portion or all of the scalp. Third, hidradenitis suppurativa (apocrine abscesses) of the axilla and groin areas occurs. This again results in sinuses and fistuli which may greatly incapacitate the individual.

Infantile Acne.—This type of acne usually occurs before the age of three months. It is more common in males and children whose parents have acne. In some of these cases the lesions are retained so that severe acne may occur in the adolescent period. Clinically, infantile acne appears as comedones and pustules. Cyst formation is rare.[4]

Treatment

Hormones.—Corticosteroids will suppress inflammation in adolescent acne and will initially relieve severe inflammatory lesions. If, however, corticosteroids are continued, they may further induce comedo formation and lead to more acne lesions. Because of the chronicity of acne vulgaris and the complications of prolonged corticosteroid therapy, systemic steroids have little or no use in prolonged treatment of acne vulgaris. Estrogens have been used to suppress acne with varying degrees of success. It is quite possible to greatly suppress sebaceous gland growth and, therefore, the formation of sebum, with estrogens if high enough dosages are used.[10] Such complications, however, as vaginal bleeding in females, feminization in males and thrombophlebitis with estrogen derivatives leaves one in a quandary as to whether or not the results are worthy of the risks.[15] Thyroid hormone has been reported by some to be successful in certain types of acne, although this has not been adequately established and its mechanisms are not clear. Gonadotropin hormone also has been used with varying degrees of success. Again if this agent

is successful, its mechanism is not clear as it would seem that gonadotropin would stimulate the production of androgens and this, in turn, would make acne worse. ACTH acts similarly to the corticosteroids in that it will initially relieve acne but if continued will induce more acne.

Antibiotics and Chemotherapy.—It recently has been shown that penicillin is by far the most sensitive drug for C. acnes in vitro.[11] In vivo, however, the drug does not produce remarkable results. Tetracycline is the next most sensitive drug in vitro and appears to be more promising when used in vivo. Some patients can be maintained on as little as 500 mg. of tetracycline per day and appear to be greatly benefited. In a recent sampling of antibiotics and chemotherapy used among dermatologists, tetracycline was by far the most popular.[12] The sulfonamides appeared to be less popular since complications are more common with the latter and the clinical results more variable.

Acne Surgery.—If properly done, incision and drainage of a cyst is quite helpful for the patient. Minimal scarring results if a 25 gauge needle is used to incise the cyst. Then if an insoluble suspension of triamcinolone acetonide is injected into the cyst, it often will involute over a period of a week.[13] Comedo extraction is exceedingly helpful, not only cosmetically but also because the primary lesion is removed. This is readily done with a 27 gauge needle and the conventional type of comedo extractor. Dermabrasion is less popular nowadays although mechanical dermabrasion with wire brushes sometimes is helpful in a given case. When used, both patient and physician should be aware of the complications of hypopigmentation and hyperpigmentation.[15] Not every patient with scarring is a candidate for mechanical or chemical dermabrasion.

Chemical dermabrasion can be performed with a more destructive acid such as trichloracetic acid which usually is not absorbed systemically. Phenol has been used in the past but can be absorbed to produce toxicity. In areas technically difficult to reach with wire brush dermabrasion, chemical dermabrasion is advantageous.

Diet.—Diet probably does not play a real factor in acne. There have been no double blind studies to date to definitely show that diet alters sebaceous gland function or the bacterial flora of the face. It is a well known phenomenon, however, that systemic infections and stress allow acne to flare.

Peeling Agents.—Salicylic acid, sulfur, resorcinol and polyoxyethylene laural ether are the commonly used agents for inducing dryness, erythema and mild peeling in the acne patient. These distinctly cause improvement although the mechanism through which they act is unknown. Local antibacterial agents such as hexachlorophene, bithionol and neomycin may be helpful. These probably reduce the bacterial flora of the skin to some degree. In vitro studies with neomycin, however, have shown that C. acnes is totally resistant to this drug. The use of bithionol in local medication is leading to an increasing number of cases of allergic contact dermatitis and photosensitivity.[17]

Miscellaneous.—Vitamin A is used by many, especially where closed comedones are prominent, although no double blind study to date has demonstrated it to be consistently rewarding. Although x-ray will cause involution of the sebaceous gland and clinical remission in acne, the full effects of x-ray are not known and at this time are greatly feared.[15] It is known that x-ray will hasten aging of the skin and probably should not be used on sun exposed areas.[4]

Summary

Clinical variants of the acne complex are described. The sebaceous follicle is pointed out as the target organ. Acne is defined as a reaction pattern involving this organ. Androgenic hormones, follicular plugging and bacterial infection act as direct factors in adolescent acne. Antibiotics, especially the tetracyclines, are effective because of their antibacterial effects upon the C. acnes population. Follicular plugging represented by the comedo is the primary lesion. This creates a dam of sebum upon which the bacteria can act.

The most effective therapeutic regimen appears to be oral antibiotics used in conjunction with peeling and drying agents. For cystic acne intralesional triamcinolone is helpful. Diet appears to be unrelated to acne. X-irradiation is hazardous and has fallen into disrepute. Systemic corticosteroids are helpful in the treatment of severely inflamed lesions but later may induce new ones.

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Special Article

A Doctor Looks at Shakespeare

Bernard W. Wilkinson, M. D.

Of Shakespeare's life we have only scrappy documents as the art of biography hardly could be said to be even in its infancy in his time. From the town records of Stratford-on-Avon it is clear that Shakespeare's family was of good middle class stock and well-to-do. The father, John Shakespeare, in 1557, married the daughter of Robert Arden, member of an ancient and distinguished Catholic family which suffered during the religious persecution at the time of Queen Elizabeth's reign.

William was the third child and the eldest son. He was baptized in the parish church of Stratford-on-Avon on April 26, 1564. Two sisters, Joan, born in September, 1558, and Margaret, born in November, 1562, had died in infancy. The Shakespeare family does not appear to have been a robust one, so it may be assumed that this first boy, William, was anxiously watched over during his infancy. A plague, of which 237 persons died between July and December, struck Statford three months after William's birth, miraculously by-passing the infant. William was followed by Gilbert, in 1566, and another child also named Joan, in 1569. Then came Anne, in 1571, who died at the age of 8 years; then Richard, in 1574, and Edmund, in 1580, who died at age 27 and 29, respectively. The most rugged of the children was the second Joan who, as Mrs. Hart, lived to age 77. William, second in physical stamina, lived to age 52.

When he was 18 years old, Shakespeare married Anne Hathaway who was 26. Their first child, Susanna, was born six months later, in 1583. In February, 1585, twins, Hamnet and Judith, son and daughter, were born to the couple. Shakespeare, in 1587, went to London, the circumstances of which are obscure though it well may have been in order to support his wife and children rather than from the urge of any distinct ambition. When Hamnet died in 1596 he attended his funeral. The three grandsons by his daughter, Judith Quiney, died in youth and, by 1670, Shakespeare had no direct descendants whatever.

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In looking over the records of the Shakespeare group, the lethal character of the early months of the year appears in sharp focus, an observation true of our own country less than fifty years ago when so many elderly persons were carried off by pneumonia early in the year. It was this obvious predilection of pneumonia for older people that inspired Osler's now famous remark about pneumonia being a friend of the aged. Shakespeare himself was stricken in the month of April when he was 52 years of age. Since there is no record of the Bard's illness, however, what he actually died of is not known although it is on record that he, Ben Jonson and some others were celebrating his daughter's wedding, when he fell into the Thames and died soon thereafter of a fever. John Hall, the prominent doctor of that community, most assuredly treated him during his last illness.

Although, as we have noted, Shakespeare was baptized on April 26, 1564, the exact date of his birth is not known. Inasmuch as children were baptized at the earliest moment possible in those days, it seems unlikely that he was born before the 21st or 22nd of April of that year.

From the information that has been obtained regarding the education of the famous poet and dramatist, seven years of grammar school appear to be the full extent of his formal schooling. The curriculum of the Elizabethan grammar school was composed almost entirely of Latin. The end of education in those days was conceived of as the ability to read, speak and write this common language of the scholars. Accompanying the study of Latin grammer were exercises consisting of conversation in Latin. The bits of Latin dialogue between schoolmaster Holofernes and the

parson in Love's Labour's Lost are modeled on such exercises and show how well Shakespeare remembered his early training. He entered grammar school in 1571 and left about 1578.

Shakespeare's first poem was Venus and Adonis. He probably was writing poetry before he started writing plays. His second poem was The Rape of Lucrece. There was very little playing throughout 1593 for an outbreak of the plague closed the theaters. Playing companies began drifting back to London in 1594.

'Tragic Period'

Shakespeare's early (until 1601) plays were comedy and those based on historical events. From 1601 to 1608 comes tragedy after tragedy: Julius Caesar, Hamlet, Othello, King Lear, Timon of Athens, Macbeth, Antony and Cleopatra, Coriolanus and their companions, plays that indeed can be called tragedies. These seven years well might be called Shakespeare's "tragic period." After that he turned to plays of a reconciling nature, "romances" as they have been called.

The fact of this distinctly tragic time when Shakespeare seems to have been occupied almost exclusively with deep and painful problems led to the suggestion that during these years of middle age, from 37 to 44, he was heavily burdened in spirit. He turned to tragedy not only because he felt himself equal to it and not only because he felt tragedy to be the greatest form of drama, but also because the world had come to look dark and terrible to him. There is no question but that Shakespeare wrestled considerably with that "daemon thought," as Byron calls it, as month after month he lived the parts and suffered with the characters he was creating for his self-identification; this is one of the secrets of his art. He suffered the jealousy of Othello, the madness of Timon and Lear, the remorse of Macbeth, the insane pride of Coriolanus and the despair of Antony. It was these periods of strain that prompted so many critics to attempt to find out what was on his mind and whether or not he was bordering on a nervous breakdown.

Unquestionably Shakespeare had the mind of a genius. As previously noted, during these years of middle age the world had begun to look dark to him. His father had died in 1601. We have no data on the cause of his father's death nor on the length of the period of his illness but many critics, in commenting on Hamlet, insist that Shakespeare's father's death played a significant part in the play's writing. Before Hamlet, Shakespeare had written no tragedies. Throughout the play he stresses the feelings of death and it is true that he turned from comedy to tragedy. Freud attaches great significance to it, remarking that to many men the death of their father perhaps is the most important event in their lives; thus, evidently the death of Shakespeare's father was a great blow to him and one from which he never fully recovered. In Hamlet he tries to convince himself that death is natural—"It is natural to lose a father."

Hamlet takes his father's death so grievously that it is unnatural. He seems to extend beyond grief into melancholia which, of course, is far different.

Shakespeare and Medicine

There seems to be no question of Shakespeare's knowledge of medicine in the Elizabethan age. He was distinctly aware of current medical thought. Although the number of medical references throughout his plays is no indication that he had any training in medicine, his medical knowledge corresponds closely to that prevailing among medicine's professors of the day; and it is true that many books have been written to show that Shakespeare had the knowledge of a professional, not only in medicine but in law, navigation, theology and many other fields of learning. It is evident from the allusions throughout the plays that Shakespeare was a reader rather than a scholar. He used books for what interested him rather than for complete mastery.

In 1607, Shakespeare's eldest daughter, Susanna, married Dr. John Hall. The young physician was making a great reputation for himself, not only in Stratford but throughout the country and beyond. Some years after his marriage, he completed a casebook, "Select Observations," which was so highly thought of that it was translated from the original latin and published 20 years after his death. Hall could have influenced Shakespeare's medical knowledge either by imparting his own knowledge of things medical or by his behavior as a doctor. We could expect, therefore, to find evidence of Hall's influence in Shakespeare's characterizations of the doctors in his plays or perhaps in his medical references.

Shakespeare used some good clinical descriptions of disease at times. He created a masterpiece in describing Falstaff's death:

Pistol: No, for my manly heart doth yearn.
Bardolph, be blithe; Nym, rouse thy vaunting veins;
Boy, bristle thy courage up; for Falstaff he is dead,
And we must yearn therefore.

Bardolph: Would I were with him, wheresome'er he is, either in heaven or in hell!

Hostess: Nay, sure, he's not in hell: he's in Arthur's bosom, if ever man went to Arthur's

bosom. A' made a finer end and went away an it had been any christom child; a' parted even just between twelve and one, even at the turning o' the tide: for after I saw him fumble with the sheets and play with flowers and smile upon his fingers' ends, I knew there was but one way; for his nose was as sharp as a pen, and a' babbled of green fields. "How now, Sir John!" quoth I: "what man! be of good cheer." So a' cried out "God, God, God!" three or four times: now I, to comfort him, bid him a' should not think of God, I hoped there was no need to trouble himself with any such thoughts yet. So a' bade me lay more clothes on his feet: I put my hand into the bed and felt them, and they were as cold as any stone; then I felt to his knees, and so upward, and upward, and all was as cold as any stone.

To the medical mind Shakespeare undoubtedly was describing a death which he had actually seen at one time or another. The appearance of the facies in this state is characteristic and has been referred to as the Hippocratic facies. This type of death was commonly seen in this country when typhoid fever was prevalent, and before the routine use of infusions and transfusions.

In King Lear there is an example of a mind that began to fail with age. Lear is an example of the tragic effects of ingratitude. Shakespeare shows the extraordinary nature of his character to his daughters. This simply is the story of an unwanted old man, an aged father, the kind that could be found today on any city street, in striking contrast to the 80-year-old monarch's formality when, on the throne, he was dividing his lands. He had become a mad old man whose tempestuousness matched the elements of nature. The most obvious symptom of his insanity, especially in the first stage, is the domination of fixed ideas. Powerful speeches are uttered by Lear in his madness. He was rather witty at times. He tells Gloucester, whose eyes have been put out—

Get thee glass eyes and like the scurvy politician
seem to see the things thou dost not see.

He seemed to have delusional trends without complete deterioration.

Later Lear has been seen in the fields, Cordelia says, "as mad as the vexed sea, singing aloud, decorated with furrowed weeds—burdock, hemlock, nettleweed, cuckoo flower."

Cordelia speaks to the doctor and asks, "What can man's wisdom in restoring his bereaved sense?"

Doctor: There is means, madam. Our fostered
nurse of nature in repose.
The which he lacks; that to provoke in
him,
Are many simples operative, whose power
Will close the eye of anguish.

Lear was then given a drug. Later, Cordelia, to the doctor:

How does the king?
Doctor: Madam, sleeps still.
Cordelia: O you kind gods:
Cure this great breach in his abused
nature!
The untun'd and jarring senses. O! wind up
Of this child-changed father!

Music is played and Lear is awakened improved, and the doctor then says:

Be comforted, good madam; the great rage,
You see, is kill'd in him; and yet it is danger
To make him even o'er the time he has lost.
Desire him to go in; trouble him no more
Till further settling.

Inability to procreate due to a rather serious consequence is revealed to the medical mind in *King Henry VIII,* when he is talking of Catherine before divorcing her because she cannot bear him a son.

Henry: First, methought
I stood not in the smile of heaven, who had
Commanded nature, that my lady's womb,
If it conceiv'd a male child by me, should
Do no more offices of life to't than
The grave does to the dead; for her male
issue
Or died where they were made, or shortly
after
This world had air'd them. Hence I took
a thought
This was a judgment on me; that my king-
dom,
Well worthy the best heir o' the world,
should not
Be gladded in't by me. Then follows that
I weigh'd the danger which my realms
stood in
By this my issue's fail; and that gave to me
Many a groaning throe. Thus hulling in
The wild sea of my conscience, I did steer
Toward this remedy, whereupon we are
Now present here together; that's to say,
I meant to rectify my conscience, which
I then did feel full sick, and yet not well,
By all the rev'rend fathers of the land
And the doctors learn'd. First, I began in
private
With you, my Lord of Lincoln; you re-
member
How under my oppression I did reek,
When I first mov'd you.

Shakespeare must have been feeling rather bitter toward mankind when he wrote *Timon of Athens.* Timon in his fury tells Apemantus that had he been born to high estate and its pleasure.

. . . thou wouldst have plung'd thyself
In general riot; melted down thy youth
In different beds of lust; and never learn'd
The icy precepts of respect, but follow'd
The sugar'd game before thee.

In *Timon of Athens* there is no affection left for man or woman, fair or dark. There is a general condemnation of sex and even of the natural fertility. Timon calls on Earth.

Ensear thy fertile and conceptions womb,
Let it no more bring out ingrateful man!
Go great with tigers, dragons, wolves, and bears;
Teem with new monsters, whom they upward face
Hath to the marbled mansion all above
Never presented!

He prays for the end of all human breeding—for the odious disruption of all humanity and may disease lick up all their blood. In this play Shakespeare presents a beautiful description of tertiary stage of syphilis in Timon's advice to the two courtesans on how to take their revenge on men.

Timon: Consumption sow
In hollow bones of man; strike their sharp shins,
And mar men's spurring. Crack the lawyer's voice,
That he may never more false title plead,
Nor sound his quillets shrilly; hoar the flamen,
That scolds against the quality of flesh,
And not believes himself; down with the nose,
Down with it flat; take the bridge quiet away
Of him that, his particular to foresee,
Smells from the general weal: make curl'd-pate ruffians bald,
And let the unscarr'd braggarts of the war
Derive some pain from you: plague all,
That your activity may defeat and quell
That source of all erection. There's more gold;
Do you damn others, and let this damn you,
And ditches grave you all!

In *Othello,* after Iago's repeated attempts to show that Desdemona was unfaithful and, finally, getting Othello to thinking along those lines, the poison begins to work and it burns like wildfire. The "madness of revenge" is in his blood, and hesitation is a thing he never knew. He passes judgment and controls himself only to make his sentence a solemn vow. The Othello in the fourth act is an Othello in his fall: "chaos has come." Iago hurries on with his subtle scheme for it was terribly dangerous to leave a chance for a meeting of Cassio and Othello, and his insight into Othello's nature taught him that the one plan was to deliver blow on blow and never to allow his victim to recover from the confusion of the first shock. When Othello reappears, we see at a glance that he is a changed man. He is physically exhausted. His mind is dazed; he sees everything through a mist of blood and tears. It is here that Othello falls into an epileptic attack. Shakespeare shows this fit on the stage. He shows the mental confusion immediately preceding the attack when Othello says:

Othello: Lie with her! lie on her! We say, lie on her, when they belie her. Lie with her! that's fulsome. Handkerchief—confessions—handerchief! To confess, and be hanged for his labour. First, to be hanged, and then to confess: I tremble at it. Nature would not invest herself in such shadowing passion without some instruction. It is not words that shake me thus. Pish! Noses, ears, and lips. Is it possible?—Confess!—Handkerchief!—O devil! (Falls in a trance).

Iago: Work on,
My medicine, work! Thus credulous fools are caught;
And many worthy and chaste dames even thus,
All guiltless, meet reproach. What, ho! my lord!
My lord, I say! Othello!

(Enter Cassio)

How now, Cassio!

Cassio: What's the matter?

Iago: My Lord is fallen into an epilepsy;
This is his second fit; he had one yesterday.

Cassio: Rub him about the temples.

Iago: No, forbear;
The lethargy must have his quiet course,
If not he foams at mouth, and by and by
Breaks out to savage madness. Look! he stirs;
Do you withdraw yourself a little while,
He will recover straight; when he is gone,
I would on great occasion speak with you.

In *Julius Caesar,* Shakespeare also mentions epilepsy, the sacred disease in his day, when he describes how Caesar refused the crown.

Casca: I saw Mark Antony offer him a crown; yet 'twas not a crown; neither, 'twas one of these coronets; and, as I told you, he put it by once, but for all that, to my thinking, he would fain have had it. Then he offered it to him again; then he put it by again; but to my thinking, he was very loath to lay his fingers off it. And then he offered it the third time; he put it the third time by; and still as he refused it the rabblement shouted and clapped their chopped hands, and threw up their sweaty night-caps, and uttered such a deal of stinking breath because Caesar refused the crown, that it had almost choked Caesar; for he swounded an fell down at it; and for mine own part, I durst not laugh, for fear of opening my lips and receiving the bad air.

Cassius: But soft, I pray you: what! did Caesar swound?

Casca: He fell down in the market-place, and foamed at the mouth, and was speechless.

Brutus: 'Tis very like: He hath the falling sickness.

Lastly, in *King John,* there is a statement on the death of the king that leads us to believe that he died in a beautiful and ecstatic euthanasia. Again to the medical mind this is very descriptive. In the orchard of Swinstead Abbey where the king had been brought:

Prince Henry: It is too late: The life of all his blood
Is touch'd corruptibly; and his pure brain,—
Which some suppose the soul's frail dwellinghouse,—
Doth, by the idle comments that it makes,
Foretell the ending of mortality.

(Enter Pembroke)

Pembroke: His highness yet doth speak; and holds belief
That, being brought into the open air,
It would allay the burning quality
Of that fell poison which assaileth him.

Prince Henry: Let him be brought into the orchard here.
Doth he still rage?

Pembroke: He is more patient
Than when you left him: even now he sung.

Prince Henry: O, vanity of sickness! fierce extremes
In their continuance will not feel themselves.
Death, having prey'd upon the outward parts,
Leaves them invisible; and his siege is now
Against the mind, the which he pricks and wounds
With many legions of strange fantasies,
Which, in their throng and press to that last hold,
Confound themselves. 'Tis strange death should sing.
I am the cygnet to this pale faint swan,
Who chants a doleful hymn to his own death,
And from the organ-pipe of frailty sings
His soul and body to their lasting rest.

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Labels on Prescriptions

In recent years more and more physicians have requested that their prescriptions be labeled as to the contents. Each physician must decide whether the advantages of this innovation outweigh the disadvantages in his own practice.

There are several reasons for not telling the patient what the medication is. The drug may be a relatively inert and the real benefit due to psychotherapy. This type of medication is now used less than in the past, but placebos still have a significant place in our armamentarium. Some patients cannot accept the fact that their illness is psychosomatic in origin; they may refuse to take a sedative and yet be willing to take an antispasmodic. Self-treatment might be a greater problem when patients know what medicine they are taking; but, limiting refills by careful enforcement of our present pharmacy laws should prevent this. Articles in magazines and newspapers describing the complications which may follow the administration of certain drugs sometimes cause patients to discontinue their prescribed medication. More effective medical editing of such articles is needed to provide patients with accurate information.

The reasons for labeling prescriptions are also based upon what is thought to be best for the patient. When the patient is seen by a second physician, the treatment can be more scientific if he knows what previous medication has been used. This is especially important for patients taking medication for a chronic illness who see different physicians in the course of their travels. This is also important for patients with multiple conditions requiring simultaneous treatment by several physicians. When the patient is seen at home the physician does not have to rely upon his memory of previous prescriptions, but he can look at the bottles and know what the patient has been taking. When the physician is called on the phone because of a change in the patient's condition it is important that the physician be accurately informed of the medication being taken at that time. Sometimes a patient may develop a new or recurrent symptom that can be treated in an efficient manner by the administration of labeled medicine that the patient already has on hand. The better informed patient is usually more cooperative and is more likely to follow instructions. Because of the frequent occurrence of allergic reactions to drugs it is essential that patients know the contents of all prescriptions.

With continued medical progress and better education of the American people it is probable that all prescriptions will be labeled in the near future.—*James M. Moss, M.D., in Virginia Medical Monthly*

97TH ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 20-22, 1964

Plan to Attend — Make Your Reservation . . . Now !

The President's Page

Points to Ponder

During the past year I have visited most of the county medical societies throughout the State as well as the annual meetings of neighboring state associations. In addition, I have had the opportunity and privilege of meeting with and participating in programs and discussions of other professional and non-professional groups. As a result of these contacts, being aware of other informative opinions, there are several issues and trends that have become very clear. I shall discuss briefly several of these for your deliberation.

In meeting the challenge of modern medicine and the demands and needs of the public in the entire health field, it is imperative that methods of continuing medical education be implemented throughout the State. There is a joint responsibility present for the encouragement and implementation of such a program. This responsibility is shared by the West Virginia University School of Medicine, the teaching staff of its hospital, the State Medical Association, county medical societies, community hospitals, and the individual physicians. After conferring with these interested groups it has indeed been gratifying to discover a cooperative spirit. The practicing physician will then still feel a part of his medical school or hospital after the completion of his internship or residency. I am sure, therefore, that a representative and continuing education committee can supply the necessary organization for the realization of such a plan.

The physician shortage in the State is still acute. This applies to all categories, and is especially true regarding general practice. To a varying degree, the situation is one of national scope. The number of physicians entering the field of general practice has decreased annually until at present the trend has reached a degree creating a partial vacuum. How can the number of young physicians entering the field of general practice be increased? The answer is difficult and has been given much thought. Some solutions include changes in the following conditions: (1) A reversal of the trend in medical education toward super-specialization and research, (2) an increased awareness of the value of bed-side clinical teaching and of the patient as an individual, (3) an increase in the number of general practice residencies in teaching medical institutions and hospitals, (4) the availability to the public of the physicians already in the field of general practice, (5) the elevation of the educational and economic standards of rural communities, and (6) the provision of adequate medical facilities for the practice of modern scientific medicine in smaller cities and towns. The above are a few of the more difficult problems demanding solution in the areas of physician shortage. National, state, and regional conferences are being held on this subject between representatives of *all* groups concerned.

The private practice of medicine is being attacked on many fronts at present, and from several approaches. One method as employed in the King-Anderson Bill, now before Congress, using the Social Security mechanism, has keenly held our attention. However, other methods are also being advocated and even used in certain areas. One development is the hospital complex for the practice of medicine, both in-patient and out-patient, being unlimited in scope, and also employing full-time physicians.

The idea of compulsory area-wide planning for hospitals has been gaining momentum throughout the nation. Enabling legislation has already been introduced in several state legislatures. The U. S. Public Health Service and the American Hospital Association were the originators of the plan, and it has since been advocated by the AFL-CIO. The scope of these plans includes ultimate federal control of medical practice. In addition, the effects on private medical practice of the Mental Retardation Bill, already passed by Congress, the proposed Appalachian Bill, and the Anti-Poverty measures, are as yet unknown with regard to the extent of involvement.

The issues and trends discussed above are intended to promote serious consideration by the medical profession in this State of the many current problems of medicine, and thereby to help in their solution.

Charles L. Goodhand

Charles L. Goodhand, M. D., President

THE WEST VIRGINIA MEDICAL JOURNAL

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EDITORIALS

NUMBER OF MEDICAL SCHOOL GRADUATES AND INCREASING POPULATION

Considerable concern has been expressed whether the number of medical school graduates is keeping pace with the increasing population of the United States. Recently a datagram was distributed by the Association of American Medical Colleges which contains data pertinent to the question. The datagram bristles with figures which need not all be duplicated in this editorial. It is of interest, however, to present some of them.

In 1955 the population of the United States was 168,270,000; the number of physicians per 100,000 population was 131.9, and the number of medical school graduates (also per 100,000 population) was 4.2; in 1962 the respective figures were: 189,209,000; 132.4; and 3.8.

The datagram emphasizes that the critical indication is the decreasing ratio of United States medical school graduates to the population since 1955. This obtains despite a 2.7 per cent increase over the same period in actual numbers. The datagram states further that although an eight year span (1955-63) is insufficient to establish a firm trend, the decreasing ratio of United States medical school graduates to the total population and its implication for future medical care is of utmost importance.

The figures, if we assume they are statistically significant, indicate that more medical schools should be built. It is of interest that in 1955 there were 83 medical schools in the United States and in 1962 there were 87. Currently there are 10 medical schools in various stages of development; these are: The University of New Mexico, South Texas Medical School (in San Antonio), Brown University, Rutgers University, Michigan State University, University of Arizona, University of California at San Diego, the University of Connecticut, the University of Massachusetts, and Penn State University.

The State of West Virginia is fortunate in these days of rising building costs and need for medical personnel to have a first-class medical center. The development of such a facility is an extremely expensive undertaking, and, futhermore, a number of years are necessary for its completion. Even though West Virginia had a two-year medical school, it took approximately a decade to develop the four-year school. The state legislature authorized the establishment of a four-year medical school in March 1951; the first class was not graduated until June 1962. It must be pointed out, however, that there was some delay in hospital construction because of a shortage of funds.

The entire problem of increasing the number of medical graduates and of building new medical centers needs careful study and long range planning. The establishment of several two-year medical schools will, of course, help increase the

number of graduates, because many of the four-year medical schools have vacancies in their third and fourth year classes. Doubtless, however, it will be necessary to build more four-year medical schools. Present figures indicate that unless each year more medical students are graduated in the United States, there soon will be a distinct shortage of physicians in our country.

SHAKESPEARE AND MEDICINE

Elsewhere in this issue is a most interesting paper by Dr. Bernard W. Wilkinson concerning the Bard of Avon. This publication is a departure from the usual scientific diet and many readers will welcome the change. This year is the 400th anniversary of the birth of Shakespeare and, despite four centuries, the greatest of honors have been heaped upon the playwright by men and women in all professions and in all lands. At least a score of books, interpreting, discussing and lauding Shakespeare have been published in the past six months and more than 500 English publications have been devoted to Shakespeare since his death. Such an outpouring of literary devotion indicates the great and sustained interest in the poet.

It is only proper for physicians to commemorate his life because Shakespeare throughout his writings has shown a precise and unusual interest in medicine. Some of our readers will recall the articles by our late editor, Walter E. Vest, on references to specific diseases such as tuberculosis and syphilis. Shakespeare's youngest daughter Susanna married Dr. John Hall of Stratford, a renowned physician of his time who studied at Cambridge and Montpelier in France. Doctor Hall had a reputation beyond the limits of Warwickshire. He was an author, deeply religious and interested in the affairs of Holy Trinity Church in Stratford. Much of Shakespeare's interest and knowledge of the medicine of his day probably was derived from his son-in-law, Dr. John Hall.

Physicians who have a desire to enlarge their study of Shakespeare will find his drama in every corner of the country in 1964. The Great Shakespearean festivals of Stratford, Connecticut, and Stratford, Canada, are within a day's drive from West Virginia.

For further reading in this delightful story, our physicians will appreciate the article, "The Humors," by John W. Draper, Ph. D., which appeared in the April 20 issue of the *Journal of the American Medical Association*. Doctor Draper is Professor of English at West Virginia University.

Another literary treat may be found in the May issue of the *Archives of Internal Medicine*. The title of the article is "Case History of Man." and the author is E. P. Scarlett of Calgary, Alberta, Canada, who concludes: "His works are in a very real sense the casebook of man expressed in some of the greatest and loveliest poetry of the world."

Then Change the Law!

Officials of the Food and Drug Administration continue to confound the medical world with their apparent intense desire for infallibility in drugs. The recent banning of Parnate from the market is a case in point.

One wonders why they are doing this. Are they making a conscientious effort to follow the law, or is there some other less obvious, perhaps political, motivation?

William S. Apple, M. D., Executive Director of the American Pharmaceutical Association, in testimony before the Congressional Government Operations Committee, did a fine job of summing up the problem when he told about a well-known drug in use for more than a century which has caused gastric hemorrhage, capillary damage, and many other medical problems. This drug—bought today without prescription—has even produced serious asthma attacks and results in countless poisonings each year. Its name: acetylsalicylic acid, or aspirin!

Doctor Apple properly asks: "...if acetylsalicylic acid had first been discovered yesterday, what scientific evidence would the Food and Drug Administration require, and how long would FDA take to approve a new drug application for aspirin?" He didn't answer this question, but based on what's going on in Washington the answer would probably be "Never."

If administrative interpretation of the new food and drug laws passed by congress means that all drugs must be completely infallible in use, for everyone, then there is only one recourse: Change the law!—The Pennsylvania Medical Journal.

Mental Disease Prevention

The keys to the rapid progress we are making in the management of emotional disturbances are the new drugs and the treatment techniques which are at our disposal. We now measure treatment in terms of days, weeks, or months instead of years and decades. These medical advances also mean that the psychiatrist no longer stands alone—all physicians, regardless of specialty, have tools and knowledge enough to diagnose and manage many forms of mental illness. Nor have we yet really touched prevention's great potential. —Millard B. Bethel, M. D., in Hawaii Medical Journal.

In levying taxes and in shearing sheep it is well to stop when you get down to the skin.—Austin O'Malley.

GENERAL NEWS

Program Completed for Annual Meeting At The Greenbrier, Aug. 20-22

Six members of the faculty at the West Virginia University School of Medicine will participate in a symposium on "Thyroid Disease" during the 97th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 20-22.

Edmund B. Flink, M. D.

Dr. William E. Gilmore of Parkersburg, Chairman of the Program Committee, announced that the symposium will be held at the third general scientific session on Saturday morning, August 22. The program has been completed for all three general sessions and will be published in the August issue of *The Journal.*

The following members of the West Virginia University School of Medicine faculty will participate in the symposium on "Thyroid Disease:"

Edmund B. Flink, M. D., Professor and Chairman of the Department of Medicine. Subject: "Hashimoto's Disease."

George G. Green, M. D., Associate Professor of Radiology. Subject: "Radiological Aspects of the Diagnosis and Treatment of Thyroid Disease."

John E. Jones, M. D., Assistant Professor of Medicine. Subject: "Iodine Metabolism and Familial Goiter."

Paul C. Desper, M. D., Fellow in Medicine, and Frank E. Medford, M. D., Resident in Medicine. Subject: "Review of West Virginia University Hospital Experience with I^{131} Treatment of Hyperthyroidism."

In addition, there will be a presentation by a member of the Department of Pathology on "Cancer of the Thyroid and Hashimoto's Disease."

Following the presentation of formal papers, the above named speakers and out-of-state speakers will participate in a panel discussion.

First General Session

The first general scientific session will be held on Thursday morning, August 20. The following physicians will appear as speakers:

John M. Howard, M. D., Professor of Surgery, Hahnemann Medical College, Philadelphia, Pennsylvania.

Eugene F. Poutasse, M. D., Devine-Poutasse Urological Group, Norfolk, Virginia.

Bayard Carter, M. D,, Professor and Head of the Department of Obstetrics and Gynecology, Duke University School of Medicine, Durham, North Carolina.

Second General Session

The speakers at the second general scientific session on Friday morning will be as follows:

Waldo E. Nelson, M. D., Professor and Head of the Department of Pediatrics, Temple University School of Medicine, Philadelphia, Pennsylvania.

Anthony F. DePalma, M. D., Professor and Head of the Department of Orthopedic Surgery, Jefferson Medical College, Philadelphia, Pennsylvania.

John C. Krantz, Ph. D., Professor and Head of the Department of Pharmacology, University of Maryland School of Medicine, Baltimore, Maryland.

Dr. Perry E. Gresham, President of Bethany College, has accepted an invitation to speak at the opening of the first general scientific session on August 20.

Dr. Norman A. Welch of Boston, President of the American Medical Association, will speak before the first session of the House of Delegates on Wednesday evening, August 19. Dr. Charles L. Goodhand of Parkersburg, President of the State Medical Association, will deliver his Presidential Address before the Second Session of the House of Delegates on Saturday afternoon, August 22.

In addition to Doctor Gilmore, the other members of the Program Committee are Drs. Robert D. Crooks of Parkersburg, George F. Evans of Clarksburg, Richard E. Flood of Weirton, Seigle W. Parks of Fairmont and Clark K. Sleeth of Morgantown.

Heavy Advance Registration

The number of reservations for rooms at The Greenbrier for the Annual Meeting in August has passed the 400 mark and it is anticipated that more than 700 persons, including physicians, their wives and guests will be in attendance.

All physicians who plan to attend the meeting are urged to make reservations as soon as possible. An early request will assure physicians, their families and guests of room accommodations.

The complete program for the meeting will appear in the August issue of *The West Virginia Medical Journal.*

Dr. P. A. Haley Installed as President Of W. Va. Chapter, AAGP

Dr. Peter A. Haley of Charleston was installed as President of the West Virginia Chapter of the American Academy of General Practice during the 12th Annual Scientific Assembly which was held at the Charleston Civic Center, May 15-17.

Doctor Haley succeeds Dr. Joseph A. Smith of Dunbar, who will serve as Chairman of the Board of Directors during the coming year.

Dr. Jack Leckie of Huntington was named president elect and will assume his duties as president at the annual meeting in Wheeling next April.

Other officers elected were as follows:

Dr. L. Dale Simmons of Clarksburg, vice president; Dr. Martha J. Coyner of Harrisville, secretary; and Dr. Del Roy R. Davis of Kingwood, treasurer.

Dr. Carl B. Hall of Charleston, a past president of the Academy, was named Editor of *Mister Doc*, official publication of the Chapter. He succeeds Dr. Seigle W. Parks of Fairmont. Dr. Marshall J. Carper of Charleston will continue as a contributing editor.

Dr. Peter A. Haley of Charleston, right, was installed as President of the West Virginia Chapter of the American Academy of General Practice at the 12th Annual Scientific Assembly in Charleston, May 15-17. He is shown with Dr. Jack Leckie of Huntington, left, president elect, and Dr. Joseph A. Smith of Dunbar, immediate past president.

The New Academy President

Doctor Haley, the new president, is a native of Charleston and received his M. D. degree in 1931 from the University of Virginia School of Medicine in Charlottesville.

He served terms as treasurer and secretary of the Academy and was named president elect at the annual meeting in 1963.

Doctor Haley also is a member of the Kanawha Medical Society, West Virginia State Medical Association and American Medical Association.

More than 200 physicians attended scientific sessions which were held during the three-day meeting at the Charleston Civic Center. Doctor Haley served as general chairman and Dr. Donald P. Brown of Kingwood was chairman of the program committee.

The Academy's House of Delegates adopted a resolution on Friday, May 15, approving the establishment of birth control clinics for the medically indigent in West Virginia.

It was also announced that a preceptorship program for students enrolled at the West Virginia University School of Medicine would be inaugurated with the opening of the fall term in September.

Doctor Smith said eight WVU students would spend three weeks each with a designated general practitioner. During that period, the student will live at the physician's home and join him on his daily rounds and office practice.

Doctor Smith called the meeting to order officially on Friday afternoon, May 15. The invocation was given by the Rev. Alfred E. Bennett of Charleston and addresses of welcome were delivered by the Hon. John A. Shanklin, Mayor of Charleston; Dr. Charles L. Goodhand of Parkersburg, President of the West Virginia State Medical Association; and Dr. Edward Jackson of St. Albans, vice president of the Kanawha Medical Society.

The scientific session that afternoon was devoted to a program sponsored by the West Virginia Thoracic

Dr. D. Frank Kaltreider of Baltimore, left, Professor of Obstetrics and Gynecology at the University of Maryland School of Medicine, was a guest speaker at the 12th Annual Scientific Assembly of the West Virginia Chapter, AAGP. He is shown with Drs. L. Dale Simmons of Clarksburg and Page H. Seckford of Charleston. In the other photo, Dr. J. C. Huffman, of Buckhannon, left, is shown with guest speakers Dr. Charles C. Wolferth, Jr., and Dr. Thaddeus L. Montgomery, both of Philadelphia; Doctor Kaltreider; Dr. William B. Kiesewetter of Pittsburgh; and Dr. George Crile, Jr., of Cleveland.

Society, the medical advisory section of the West Virginia Tuberculosis and Health Association. Dr. William L. Cooke of Charleston, President of the National Tuberculosis Association, served as moderator of a panel discussion following presentation of papers.

Eighteen Guest Speakers

Eighteen prominent physicians and surgeons appeared as guest speakers at the scientific sessions held during the meeting. Moderators, in addition to Doctor Cooke, were Drs. J. C. Huffman of Buckhannon, Myer Bogarad of Weirton and Seigle W. Parks of Fairmont.

It was announced during the meeting that the 13th Annual Scientific Assembly will be held at Oglebay Park in Wheeling, April 30-May 2, 1965. Doctor Leckie will serve as general chairman with Drs. H. L. Hegner of Wellsburg, M. A. Gaydosh, Jr., of Wheeling and Myer Bogarad of Weirton in charge of local arrangements.

Dr. John W. Hash of Charleston served as toastmaster for the annual banquet which was preceded by a social hour. The Past President's Key was presented to Doctor Smith by Dr. Randall Connolly of Vienna, a past president of the Academy. Entertainment included accordion selections by Mrs. Edyth Hill Brigode and a comedy act featuring Bolivar and Clyde.

Mrs. William D. Crigger of South Charleston was in charge of the entertainment program for wives of physicians attending the meeting. Serving on the committee with her were Mesdames Peter A. Haley, Marshall J. Carper, Edward Jackson and Dr. Jean P. Cavender.

Dr. Martha J. Coyner of Harrisville, center, was elected secretary of the West Virginia Chapter, AAGP, at its 12th Annual Scientific Assembly. She is shown with Drs. Jean P. Cavender, left, and Rose H. McClanahan, both of Charleston. (Photo courtesy of The Charleston Daily Mail).

Out-Migration of Younger Age Group Increases State's Health Problem

Out-migration of persons in younger age-groups, decreasing numbers of births and increasing deaths are major factors contributing to West Virginia's serious losses in population during the past 12 years.

State Director of Health Dr. N. H. Dyer, writing in his weekly State of the State's Health, discussed the recent population estimate report released by the Department of Agricultural Economics at West Virginia University.

Doctor Dyer noted that since 1952, when the first serious decline was recorded, the population has dropped 142,811. Proportionately, the majority of losses can be linked to persons leaving the State and similar factors related to our depressed economy. But, using 1952 as a base period, steady losses in birth and increased deaths accounted for 37.25 per cent of the decrease—a total of 84,751 persons. From 1950 to 1960, West Virginia registered a decrease among persons under-45 of 41.1 per cent. During this same period, numbers over-45 increased by 32.8 per cent.

About one person in four over-45 in West Virginia suffers from some type of chronic illness requiring professional care. Doctor Dyer said that population losses—as they have occurred here among younger persons—have resulted in disproportionate numbers in the older age-groups, adding to our total health problem. Declining birth rates and increasing death rates, a reflection of an aging population and depressed economic conditions, further accentuate the need for a broad expansion of health services.

Heart disease, cancer, strokes and arteriosclerosis—diseases that take their heaviest toll among persons over-45—now account for nearly 70 per cent of all deaths in the state each year. Excessive deaths and disability from infectious diseases, such as tuberculosis and influenza, to which older persons are especially subject, must be added.

Sanitation Effective Weapon Against Hepatitis

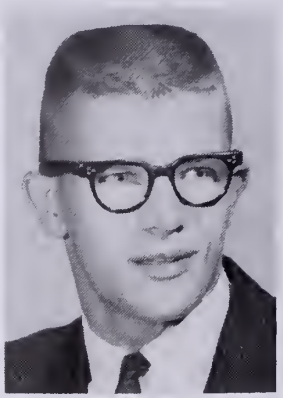
In another issue of the publication, the four-year epidemic of infectious hepatitis experienced in West Virginia was discussed. In 1959 the State had only 323 cases. By the end of 1960, the total jumped to 906—and in 1961, to 1619. By the end of 1962, the case load tapered off to 909, with a further decline to 700 cases in 1963. No significant reduction has been noted in 1964—274 cases have been reported so far against 307 for the same period last year.

The most effective weapon for prevention is personal and community hygiene since the virus has not been isolated, he said. Although much of the spread is from person to person, many authorities are convinced that initial cases result from breakdowns in environmental sanitation. Their views are substantiated by epidemiological investigations. When they have been able to pinpoint the source of infection in localized outbreaks, the reason is often polluted water or shellfish taken from such sources.

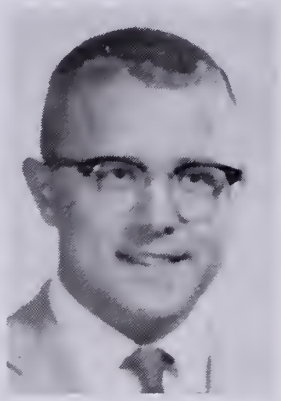
Doctor Dyer pointed out an outbreak of disease 18 months ago in Jefferson County. When chlorine added to water was increased far above normal, the cases declined. Two years ago, in Nicholas County, an epidemic was also traced to contaminated water. Similar situations in many other states have indicated breakdowns in sanitation.

Two 1964 Scholarship Recipients Selected by Committee

Carl E. Nichols of Glenville and Byron L. Van Pelt of Bethany have been selected by the Medical Scholarships Committee of the West Virginia State Medical



Carl E. Nichols



Byron L. Van Pelt

Association as the 1964 recipients of the four-year scholarship awards to the West Virginia University School of Medicine.

Announcement of the awards was made by Dr. J. P. McMullen of Wellsburg, the Chairman, following a meeting at the Medical Center in Morgantown, May 23-24.

The scholarships, each worth $4,000, are awarded annually to students enrolled in the first-year class at the School of Medicine. The two recipients will accept the awards formally during the 97th Annual Meeting of the State Medical Association at The Greenbrier in White Sulphur Springs in August.

Mr. Nichols, 21, is the son of Mr. and Mrs. Guy E. Nichols of Glenville. He was graduated from Glenville High School and had his pre-medical training at Glenville State College.

Mr. Van Pelt, 22-year-old son of Mrs. Lorraine Van Pelt of Bethany, was graduated from Bethany High School. He took his undergraduate work at Bethany College.

The two men will begin their studies in September as freshmen in the WVU School of Medicine. They are the ninth and tenth students to receive scholarships under the program inaugurated by the State Medical Association in 1958. The Association awarded one scholarship per year until 1961, and the House of Delegates voted that year to provide an additional annual scholarship.

Annual Duke Medical Seminar-Cruise

West Virginia physicians have been invited to join the 10th Postgraduate Seminar-Cruise this fall which will be sponsored by the Duke University School of Medicine.

The cruise will take physicians to the West Indies. The M. S. Kingsholm will sail from New York on November 4 for the 12-day cruise.

Further information on the Medical Seminar-Cruise may be obtained by writing the Allen Travel Service, Inc., 565 Fifth Avenue, New York 17, New York.

State Medical Association Lists Names of New Members

The following is a list by component societies of new members of the West Virginia State Medical Association elected since January 1, 1964:

Barbour-Randolph-Tucker

Harrington, A. E.	Elkins
Leonard, Walter G.	"

Boone

Beruben, Miguel F.	Madison

Cabell

Burns, Wendell M.	Huntington
Dominquez, Fernando	"
Hagley, Ray Russell	"
Irons, George B., Jr.	"
Nale, Thomas W.	"

Hancock

Teets, H. Jackson	Weirton

Harrison

Kalaycioglu, Mehmet V.	Shinnston

Kanawha

Hamaty, Daniel	Charleston
Pitsenberger, Henry J.	Belle

Logan

Portales, Ramon	Holden

Marshall

DeLisio, John	Moundsville

Mason

Walden, Robert E.	Lakin

McDowell

Dye, Robert E.	Welch
Hatfield, Johnny R.	"

Mercer

Thomas, James P.	Bluefield

Mingo

MacKay, Alexander M.	Williamson
Walker, Russell H.	"

Monongalia

Currie, Richard A.	Morgantown
Edmundowicz, A. C.	"
Green, George G.	"
Howes, Thomas C.	"
Lucas, Russell V., Jr.	"
Phillips, Ruth M.	"
Stemple, Margaret I.	"
Strader, Janet H.	"
Welton, William A.	"

Ohio

Park, William F.	Wheeling
Pentecost, G. J., Jr.	"

Parkersburg Academy

Bailey, R. J.	Parkersburg
Bernhardt, Donald R.	"
Gillespie, Frederick D.	"
Pagan, Jose A.	Pennsboro
Strawn, Lucian	Parkersburg

Preston

Rocha, Hilton	Hopemont

Raleigh

Barnes, Asa	Beckley
Belton, A. David	"
Lee, Stephen T. J.	"
Stevenson, Clifford A.	"
Wilson, Thomas C.	"

Dr. William L. Cooke Installed As President of NTA

Dr. William L. Cooke of Charleston was installed as President of the National Tuberculosis Association during the 60th Annual Meeting which was held at the Statler-Hilton Hotel in New York City, May 24-27. He succeeds Peter W. Janss of Des Moines, Iowa.

Doctor Cooke, an Associate Editor of *The West Virginia Medical Journal*, was named president elect of the NTA at its 1963 meeting which was held in Denver, Colorado.

The first West Virginian to head the 50,000-member organization, Doctor Cooke termed volunteer workers "the catalytic agents that translate the philosophy behind health programs into public acceptance."

"We need professional guidance," he told NTA directors, "but we must not ever lose sight of the the contribution and enthusiasm of volunteers, nor their ability to interpret health to the public. Without them, organizations like ours would soon lose all their value."

Doctor Cooke said the role of volunteers within the NTA will continue to grow. The entire field of respiratory diseases has been adopted by the organization.

On Tuesday evening, May 26, Doctor and Mrs. Cooke were guests of honor at a reception given personally by the members of the Board of Directors of the West Virginia Tuberculosis and Health Association at the Statler-Hilton Hotel. Over 300 guests attended, including the following West Virginians:

Dr. and Mrs. John J. Lawless, Dr. Charles E. Andrews, Dr. Ernest W. Chick, Dr. G. R. Maxwell, Dr. Charles F. Dent, Dr. Benjamin M. Stout, Jr., and Mrs. Thelma Yeager of Morgantown; Mrs. Robert F. Meighen of Weirton; Dr. and Mrs. George F. Evans, Mrs. Eleanor Cordray, R.N., Miss Rhoda Guitierrez and Mrs. Alex Stout of Clarksburg; Dr. and Mrs. Ralph H. Nestmann, Mrs. Katherine Brown and Mr. and Mrs. Thomas A. Deveny, Jr., Charleston; Mrs. C. C. Lewis, Beckley; Miss Lillian McGuire, Ronceverte; Mr. Melvin H. Lively, Rupert; and Dr. W. P. Bittinger of Summerlee, Fayette County.

The West Virginia Tuberculosis and Health Association will honor Doctor Cooke at its 56th annual meeting in October at Clarksburg.

Dr. William L. Cooke of Charleston, center, President of the National Tuberculosis Association, is shown with members of the committee that planned a reception honoring him and Mrs. Cooke at the 60th Annual Meeting of the NTA in New York on May 26. Shown with Doctor Cooke, left to right, are Mrs. Robert F. Meighen of Weirton, Dr. George F. Evans of Clarksburg, Dr. Ralph H. Nestmann of Charleston and Dr. John J. Lawless of Morgantown, president of the West Virginia Tuberculosis and Health Association.

This is the third class to graduate from the West Virginia University School of Medicine in Morgantown. The 38 young men and two women received their M. D. degrees on June 1. First row, left to right: Joseph J. Renn, III, of Martinsburg; David M. Bear, Fairmont; David R. Hobbs, Morgantown; Thomas O. Dotson, Summersville; Joseph A. Barta, Jr., Anawalt, McDowell County; Karl V. Metz, Morgantown; and Donald G. Klinestiver, Keyser.

Second row: John N. Chokatos, Clarksburg; George R. Baise, Huntington; E. Lyle Gage, Jr., Bluefield; Ruby E. Lemley, Fairview; Thomas E. Richardson, Lewisburg; Donald E. Southern, Williamson; Louis A. Fabian, Monongah; Paul H. Price, Jr., Morgantown; Roger E. King, Morgantown; W. Scott Bowie, Morgantown; Charles V. Stewart, Mullens; Edward J. Shahady, Fairmont; Ernest G. Sayfie, Charleston; Spencer L. Bivens, Jr., Charleston; William A. Morrison, Terra Alta; Susan S. Gustke, New Cumberland; John A. Karnoupakis, Weirton; Benjamin L. Plybon, Huntington; Glenn Buchanan, Gilbert; and Lewis M. Judy, Romney.

Third row: William J. Hanshaw, Dunbar; Tommy J. Altizer, Mallory, Logan County; Antonio S. Licata, Weirton; James A. Lilly, Huntington; John S. Palkot, Morgantown; Paul V. Watson, Huntington; James L. Schmidt, Bridgeport; William J. Echols, Richwood; and Nazem Abraham, Williamson. Bernard J. Mullen of Seattle, Washington, James M. Heaster of South Charleston, and Richard H. Garretson of Huntington were absent when the picture was made.

Mrs. Lyda Plymale New President Of Medical Assistants Assn.

Mrs. Lyda Plymale of Huntington was installed as president of the West Virginia Association of Medical Assistants during the annual meeting at the Prichard Hotel in Huntington, May 15-17. She succeeds Mrs. Eulalia Hanly of Charleston.

Mrs. Lyda Plymale

Mrs. Juanita Rauch of Parkersburg was named president elect; Miss Betty Keffer of Nitro, vice president; Mrs. Airy Nahodil of Charleston, recording secretary; and Mrs. Carol Keller of Parkersburg, treasurer. Dr. Fred H. Albee of Daytona Beach, Florida, an advisor to the National Association of Medical Assistants, was the installing officer.

Mrs. Plymale named Mrs. Patsy Hudson of Huntington as corresponding secretary; Miss Keffer, parliamentarian; Mrs. Alice Hussey of Charleston; historian; and as committee chairmen, Mrs. Bette Hicks of St. Albans, education; Miss Keffer, membership; Mrs. Keller, budget and finance; Mrs. Hussey, nominating; Mrs. Hanly, constitution and by-laws; and Mrs. Betty Clark of Huntington, publicity and public relations.

Mrs. Hazel Magee of Beckley was elected to a three-year term on the Association's Board of Directors. Other members of the Board are Mrs. Maxine McDaniel of Huntington and Mrs. Juanita Rauch of Parkersburg.

Drs. M. L. White, Jr., of Huntington, Morris H. O'Dell of Charleston, Charles L. Goodhand of Parkersburg, I. B. Anderson of Beckley and T. G. Harper of Weirton were named advisors for the coming year.

Mrs. Plymale, the founder and first president of the Cabell Medical Assistants Society, Mrs. Hicks and Mrs. Mary E. Kessler of Beckley were named delegates to the National Medical Assistants Convention in Oklahoma City, October 13-18. Mrs. Dymple Halstead of Beckley, Mrs. Grace Robb of Weirton and Mrs. Carol Keller of Parkersburg were named alternates.

Tentative plans were made to hold the seventh annual convention of the Association in Beckley, May 15-16, 1965.

Health Insurance Benefits

Health insurance benefit payments by insurance companies during 1963 amounted to nearly $4.2 billion, the Health Insurance Institute reported recently.

The Institute, in reporting final 1963 insurance company benefit figures said the $4,151,589,000 in health insurance benefits paid out last year was 10.3 per cent more than the $3,762,509,000 distributed during 1962.

The Advisory Committee to the West Virginia State Medical Association's Rural Health Committee met recently to complete plans for the 17th Annual Rural Health Conference at Jackson's Mill on October 1. Left to right, Mrs. Charles Elliott of Beatrice; Dr. Earl L. Fisher of Gassaway, Chairman; Mrs. Pat A. Tuckwiller of Charleston, President of the Woman's Auxiliary to the State Medical Association; Dr. N. H. Dyer of Charleston, State Director of Health; and Miss Gertrude Humphreys of Morgantown, State Leader, Home Demonstration Work.

Public Health Service Conducting X-Ray Study in West Virginia

State Health Director Dr. N. H. Dyer has urged all practicing physicians and medical facilities in West Virginia to cooperate in the current study by the U. S. Public Health Service.

The national study is assessing the population exposure from various types of x-ray examinations and procedures. Surgeon General Luther L. Terry said that the USPHS seeks information that will help the medical and dental professions make more efficient use of x-ray equipment.

The data collection phase of the current study began in April with a household interview survey in which x-ray visit information was obtained for the preceding three month period. Follow-up questionnaires and film packs, designed to provide the required exposure information, will be mailed to practitioners or facilities identified in the household survey through September, 1964. It is estimated that approximately 6,000 x-ray facilities will be involved during this period.

"The cooperation of all practitioners or facilities in West Virginia receiving follow-up requests is essential to meet the objectives of the study," Doctor Dyer said. A number of efforts have been made in the past to obtain information about x-ray exposure in this country, but these studies have been limited to selected populations or to certain types of examinations.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Steve J. Soltis Named Director Of Pallottine Hospitals

Mr. Steve J. Soltis, formerly of Beckley, was recently named Executive Director of four West Virginia hospitals operated by the Sisters of the Pallottine Missionary Society.

Hospitals under Mr. Soltis' supervision will be St. Mary's of Huntington, St. Vincent Pallotti in Morgantown, Sacred Heart in Richwood and St. Joseph's in Buckhannon.

Mr. Soltis is a native of Iowa and was graduated from Iowa State College. He has served for the past eight and one-half years as administrator of Beckley Memorial Hospital in Beckley.

No Convention Registration Fee

No registration fee will be assessed against either members or guests in connection with the 97th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 20-22, 1964.

A cordial invitation to attend all sessions has been extended by the Program Committee to interns and physicians serving a residency in hospitals in West Virginia and adjacent states.

Requests for hotel accommodations should be mailed directly to the Reservation Manager, The Greenbrier, White Sulphur Springs.

Mrs. John W. Hash Named Chairman Of State Mental Health Group

Mrs. John W. Hash, wife of a Charleston physician, was elected permanent chairman of the Governor's Advisory Committee on Mental Health at a meeting held at the Daniel Boone Hotel in Charleston on May 15.

Dr. Boylston D. Smith, Jr., of Clarksburg, was named vice chairman and Mrs. Nathan C. Eastman of Charleston, secretary.

The Governor's Committee was organized last year to survey West Virginia's needs in mental health facilities. A formal report will be made to Governor W. W. Barron before the opening of the 1965 session of the Legislature in January.

Annual Caleb Fiske Prize

The subject has been announced for this year's Caleb Fiske Prize of the Rhode Island Medical Society—America's oldest medical essay competition. Physicians throughout the country are eligible to participate and a cash prize of $500 will be awarded to the winner.

The subject chosen is "Recent Advances in the Control of Respiratory Virus Diseases, Including the Exanthemata." Entries must be typewritten, double spaced and should not exceed 10,000 words. Essays must be submitted by December 11, 1964, to the Secretary, Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence, Rhode Island 02903.

Dr. Charles A. Hoffman Reelected Treasurer of AUA

Dr. Charles A. Hoffman of Huntington, a past president of the West Virginia State Medical Association, was reelected treasurer of the American Urological Association at the 59th Annual Meeting in Pittsburgh, May 11-14.

Charles A. Hoffman, M. D.

Doctor Hoffman has been active for many years in the AUA and served for three years as Chairman of the Public Relations Committee. He is a past president of the Mid-Atlantic Section of the AUA.

He currently is serving as one of the two West Virginia delegates to the American Medical Association and also is Chairman of the Insurance Committee of the State Medical Association.

In addition to Doctor Hoffman, other officers elected by the AUA are as follows:

Dr. Hugh Judge Jewett of Baltimore, president, succeeding Dr. Richard Chuete of Brookline, Massachusetts; Dr. Rubin H. Flocks of Iowa City, Iowa, secretary; and Dr. Wirt B. Dakin, Los Angeles, historian.

Two Physicians, WVU Medical Center Recipients of Cancer Grants

West Virginia scientists and institutions have received research grants totaling $72,049 from the American Cancer Society.

Dr. John C. Condry of Charleston, president of the Society's West Virginia Division, said the grants awarded in this area "are increasingly contributing to the goals of the Society's research program to find the causes of cancer and ways to cure and prevent it."

Dr. Cornelia Hoch-Ligeti of Martinsburg, Dr. Alvin L. Watne of Morgantown and the West Virginia University Medical Center are the recipients of the currently active ACS grants.

Doctor Hoch-Ligeti, a member of the staff at the Martinsburg VA Center, is doing research on the effect of cancer-causing chemicals on human epithelial cells from the bronchial tubes.

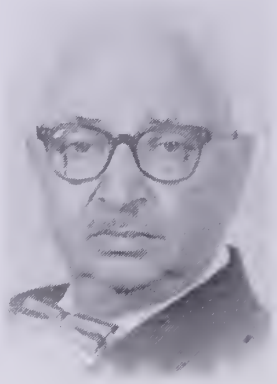
Doctor Watne, Associate Professor of Surgery at the WVU School of Medicine, is studying the reaction of human beings to the presence of cancer and metastasis. The Medical Center grant provides unearmarked funds to stimulate new cancer research.

Two State Physicians Certified

Two West Virginia physicians were certified recently as Diplomates of the American Board of Pathology. They are Drs. Enrique Aguado of Huntington and Edward G. Stuart of Morgantown.

W. Va. Allergy Society Plans Meeting At The Greenbrier on Aug. 20

A "Symposium on Gastrointestinal and Food Allergy" will be sponsored by the West Virginia State Society of Allergy during the 97th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 20-22.



Frederick A. Stenbuck, M. D.

Maurice Kaufmann, M. D.

Dr. Merle S. Scherr of Charleston, Secretary of the Society, announced that the guest speakers on Thursday afternoon, August 20, will be Dr. Maurice Kaufmann of Lexington, Kentucky, and Dr. Frederick A. Stenbuck of Mount Vernon, New York.

Doctor Kaufmann, who is Clinical Associate Professor of Pediatrics at the University of Kentucky College of Medicine, received his M. D. degree from the University of Louisville School of Medicine and is certified by the American Board of Pediatrics. He will present a paper on "Food Allergy in Children and Adults."

Doctor Stenbuck, who will speak on "Gastrointestinal Allergy," was graduated from Cornell University and was awarded graduate degrees at both New York and Columbia Universities before receiving his M. D. degree from the Columbia University College of Physicians and Surgeons. He was in charge of the Allergy Clinic at Montefiore Hospital in New York City, 1937-60, and is now Attending Allergist at the Mount Vernon Hospital in Mount Vernon, New York.

Dr. Charles L. Leonard of Elkins is president of the West Virginia State Society of Allergy and Dr. Myer Bogarad of Weirton, vice president.

Medical Meeting, 1964

The following is a partial list of national, state and district medical meetings scheduled for 1964:

Aug. 20-22—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 4—W. Va. Heart Assn., Huntington.
Sept. 10—Cabell County Symposium, Huntington.
Oct. 1—Rural Health Conf., Jackson's Mill.
Oct. 11-15—ACCP Congress, Mexico City.
Oct. 23-25—Potomac-Shenandoah Valley PG Institute, Martinsburg.
Oct. 23-25—American Heart Assn., Atlantic City.
Nov. 16-19—Southern Medical, Memphis, Tenn.
Nov. 29-Dec. 2—AMA Clinical Meeting, Miami Beach.

New Association Members

Dr. Donald R. Bailey, 403 Atlas Building, Charleston (Kanawha). Doctor Bailey was born in Bluefield and was graduated from the University of Virginia. He attended the two-year WVU School of Medicine and received his M.D. degree in 1958 from the Medical College of Virginia. He interned at Charleston Memorial, 1958-59, and served residencies at Charleston Memorial Hospital and Charleston General Hospital, 1959-63. His specialty is general surgery.

* * * *

Dr. John J. Battaglino, Jr., 303 Central Union Building, Wheeling (Ohio). Doctor Battaglino, a native of Bluefield, attended the two-year WVU School of Medicine and received his M. D. degree in 1955 from the Medical College of Virginia. He interned at City Hospital in Worchester, Massachusetts, 1955-56, and served a residency at the Mayo Foundation in Rochester, Minnesota, 1956-59. He also took postgraduate work at the University of Vienna. He previously served as a Captain in the Medical Corps of the United States Army and his specialty is obstetrics and gynecology.

* * * *

Dr. Richard A. Currie, WVU Medical Center, Morgantown (Monongalia). Doctor Currie, a native of Montreal, Canada, was graduated from McGill University and received his M. D. degree in 1948 from McGill University School of Medicine. He interned at Royal Victoria Hospital in Montreal, 1948-49, and served a residency at Massachusetts General Hospital in Boston, 1949-54. He served as a Captain in the Medical Corps of the United States Air Force, 1955-57, and currently is serving as Assistant Professor of Surgery at the WVU School of Medicine.

* * * *

Dr. George G. Green, WVU Medical Center, Morgantown (Monongalia). Doctor Green, a native of Bound Brook, New Jersey, was graduated from Rutgers University and received his M. D. degree in 1943 from New York Medical College. He interned at Kings County Hospital in Brooklyn, 1943-44, and served a residency at the Flower and Fifth Avenue Hospital in New York City. He served as a Captain in the Medical Corps of the United States Army, 1945-47, and he was certified by the American Board of Radiology in 1950. He was previously located in Asbury Park, New Jersey, and he is currently serving as Associate Professor of Radiology at the WVU School of Medicine.

* * * *

Dr. William F. Park, The Wheeling Clinic, Wheeling (Ohio). Doctor Park was born in Alexandria, Louisiana, and he received his M. D. degree in 1946 from the University of Maryland School of Medicine. He interned at the United States Naval Hospital in Great Lakes, 1946-47, and served for ten years with the Medical Corps of the United States Navy before being discharged with the rank of Commander. He is certified by the American Board of Ophthalmology.

The West Virginia Medical Journal

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Small Series of Lymphograms With Clinical Applications

Fernando Dominguez, M. D., Charles C. McKay, M. D., and Hans Dransfeld, M. D.

Encouraged by recent articles regarding lymphangiography, we studied eight patients suitable for the procedure. It is well known that lymphatic vessel and node pathology in many cases is clearly demonstrated by lymphogram.

Our experience with the method also confirms its value in determining lymph node metastasis, evaluation of cases in which there is fever of unknown origin and lymphoma is suspected, as a guide in determining the advisability of surgery, as well as a guide for accurate portal placement in radiation therapy. Lymphangiography has been shown to be of benefit also in the demonstration of lymphatic anomalies and evaluation of chronic edema secondary to lymphatic obstruction.

Lymphangiography is visualization of the lymphatic system by x-ray after its opacification by injection of contrast material. The technique is time-consuming and has not basically changed since Kinmonth's description in 1952. Minor modifications are frequent, according to the operator's preference of routine.

Outline of Technique

In our series of cases a mixture of Evans blue dye with procaine was injected intradermally (Figure 1), followed immediately by a cut-down on the dorsum of the foot or the hand. The dye is absorbed rapidly, with visualization of the lymphatics in less than ten minutes. The larger lymphatic vessel is dissected and threaded with a 30 gauge needle connected to a syringe by means of a polyethylene tube. The syringe in turn is incorporated in a C clamp (Figure 2) which allows slow, regulated injection of medium, thus avoiding the hazard of rupture of the lymphatic vessel. The opaque medium utilized was Ethiodol which has been widely used and is an ethyl ester of

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Figure 1. Intradermal injection of Evans blue dye in web space with development of wheal (same technique is used in foot).

poppy seed oil containing 37 per cent iodine. The speed of injection is approximately 1 cc. per 6 minutes with approximately 10 cc's. of medium injected. Undue pressure to increase speed leads to rupture of the lymphatic vessel with extravasation of the medium. Following injection of a small amount of Ethiodol, the lower part of the extremity is fluoroscoped to make certain that a lymphatic vessel has been injected rather than a small vein. Films are obtained immediately following the injection as well as later on, at intervals of several hours to 24 hours or longer.

In our study, we were particularly interested in proven cancer patients (Cases 1 to 6). Two cases were for diagnostic investigation, in one of which the difference between benign and malignant pathology was established (Case 7); in the other case a malignant retroperitoneal lymphoma was clinically entertained but excluded by lymphography (Case 8).

Clinical Material
(Patients Studied)

1. Postsurgical status (18 months following panhysterectomy for carcinoma of the cervix) —normal lymphogram.

2. Postsurgical status (33 months following abdominoperineal resection for adenocarcinoma of the rectum)—normal lymphogram.

3. Postsurgical status (8 days following hysterectomy and left salpingo-oophorectomy for carcinoma of the left fallopian tube). Lymphogram was abnormal and the patient was referred to the x-ray department for treatment.

4. Sixty-four year old female, abdominoperineal resection, one year postoperative for carcinoma of the rectum. Lymphogram negative.

5. Post x-ray treatment and insertion of radium (9 months) for carcinoma of the cervix—normal lymphogram.

6. Post x-ray treatment (8 months) for carcinoma of the cervix. Lymphogram was abnormal, showing invasion of deep pelvic nodes and peri-aortic chain.

7. Patient with severe stricture of esophagus in which the diagnosis of peptic esophagitis was made with the lesser possibility of carcinoma not being excluded—normal lymphogram.

8. Medical patient with history of fever of undetermined origin of four months' duration in which diagnosis of retroperitoneal lymphoma was entertained—normal lymphogram.

All patients have been seen in the tumor clinic of this hospital one year after lymphogram, sup-

Figure 2. C clamp is used in injection of dye at gradual and slow rate.

Figure 3. AP and lateral films of leg showing lymphatic channels filled with Ethiodol.

Figure 4. Film of pelvis showing inguinal and deep pelvic nodes in normal position and with normal anatomic configuration.

porting the accuracy and aid of the method in clinical evaluation. Of the eight cases studied, three which proved to be of particular interest are reported.

The following case is presented as an example of a normal lymphogram study (Case 1 above).

Case Reports

A 31-year-old white female was admitted to the hospital with the chief complaint of vaginal bleeding of four weeks' duration. A cervical biopsy specimen was obtained because of clinical findings consistent with stage I carcinoma of the cervix. The biopsy was positive.

The patient received x-ray therapy and seven weeks later underwent panhysterectomy with a modified Wertheim procedure. Eighteen months later lymphangiography was performed which showed a normal lymphogram. The lymphatic vessels (Figure 3) of the lower extremities as well as the pelvic and aortic nodes (Figures 4 and 5) are seen.

The second case is an example of the aid of lymphangiography (Case 6 above) in the matter of deciding against extensive surgery which would not have been of benefit to the patient.

A 42-year-old white female came to the hospital with the chief complaint of vaginal bleeding of two weeks' duration. Pelvic examination revealed stage III carcinoma of the cervix. The biopsy specimen showed epidermoid carcinoma, grade II. X-ray therapy was given and two months later a cervical biopsy was negative.

After four months she was readmitted to the hospital with vaginal bleeding and erosion of the cervical region, without pelvic masses. Biopsy showed recurrence, and pelvic exenteration was planned. Prior to surgery, lymphangiography showed three abnormal lymph nodes (Figure 6): a deep pelvic node on the left side and two nodes in the right periaortic chain. Exploratory laparotomy confirmed the lymphogram findings in that the suspicious nodes of the aortic chain were removed and on frozen section showed metastatic invasion. The procedure was terminated at that point because it was felt that the patient was beyond any possibility of cure. She was followed on outpatient basis and died eight months later.

The third case exemplifies the aid afforded by lymphangiography in the differentiation of a benign lesion from a malignant process (Case 7 above).

A 45-year-old white female was admitted to the hospital with the chief complaints of regurgitation, difficulty in swallowing and marked weight loss.

Figure 5. KUB, 24-hour film showing lymph nodes of peri-aortic chains. Film can be taken also at end of injection of dye. This film is interpreted as a normal lymphogram.

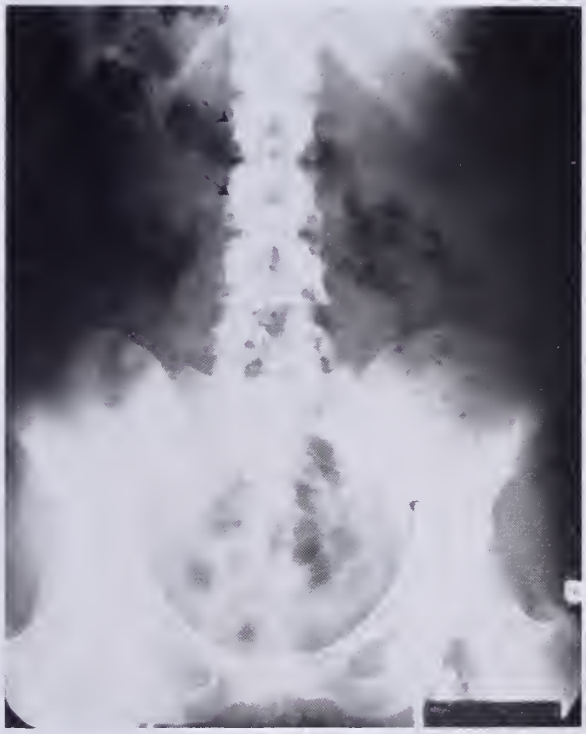

Figure 6. Abnormal deep pelvic lymph node on left side with its "moth-eaten" appearance. Note that node also is enlarged. At exploratory laparotomy node was found to be hard and was fixed to pelvic wall. There are two abnormal lymph nodes in right peri-aortic chain; frozen section after their removal showed metastatic invasion (second case report).

Barium studies of the esophagus showed marked constriction of the lower third of the esophagus (Figures 7 and 8) which was interpreted as esophagitis with the possibility of carcinoma not excluded. Esophagoscopy was performed with the impression of possible tumor; biopsy specimens, however, were negative. The lymphogram was normal which tended to exclude neoplastic nodal involvement, and nonsurgical treatment was instituted. The patient failed to respond to the medical treatment, her condition became worse and, finally, partial esophagectomy was carried out, with marked improvement. The resected segment of the esophagus showed chronic esophagitis without malignant change.

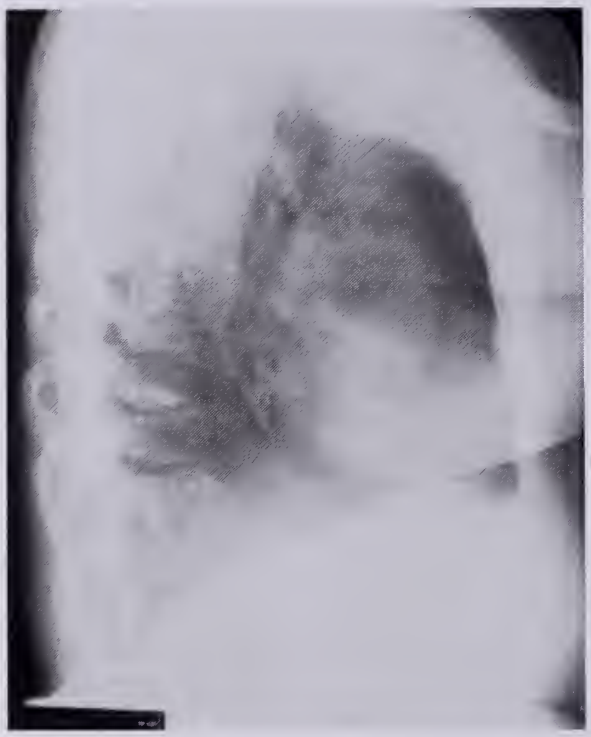

Figure 7. Esophagus following barium swallow, showing marked narrowing of lower third.

Figure 8. Spot films of lower third of esophagus which gave impression of possible carcinoma (third case report).

There were no complications which could be attributed to the procedure in any of our cases. The occasional complications such as infection at the injection site, sensitivity reaction to the iodine, pulmonary infection, or infarction secondary to embolization of the oily medium should be kept in mind.

Summary

1. It is our conclusion that lymphangiography is helpful in the diagnosis and treatment of many malignant conditions, and we emphasize its value in selected cases in which neoplastic nodal involvement is suspected.

2. The recent use of a dye in the contrast medium helps greatly in identification of nodes in those cases in which a subsequent lymph node dissection is anticipated.

3. In cases of metastatic invasion, the lymph nodes have a "moth-eaten" appearance and may be normal in size or may be enlarged. In cases of lymphoma they have a foamy-lacy appearance with a general increase in the size of the involved nodes.

4. The procedure is not harmful and the complications, if any, are inconsequential.

5. In our study, the conclusions arrived at from viewing the lymphograms have been substantiated by subsequent clinical follow-up of the patients.

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Primary Varicella Pneumonia

George E. Farrell, M. D., and Arthur M. Benshoff, Jr., M. D.

The purpose of this paper is to present a rather unusual case of primary chickenpox pneumonia that developed in a 28-year-old negro male. The pneumonia was practically asymptomatic although x-ray demonstrated extensive infiltration throughout both lung fields. The infiltration cleared completely in a few days and the patient was discharged entirely well.

Reference to the disease is relatively infrequent in the literature although multiple case reports can be found. In those cases reported, the pneumonia generally offered severe signs and symptoms and frequently resulted in death.[1,2,3] The difference between our case and the majority of those reported in the literature is that the patient in our case showed practically no symptoms and made a complete recovery.

The Authors

- **George E. Farrell, M. D., Department of Radiology, Greenbrier Valley Hospital, Ronceverte, West Virginia.**
- **Arthur M. Benshoff, Jr., M. D., Department of Medicine, Greenbrier Valley Hospital, Ronceverte, West Virginia.**

Case Report

A 28-year-old negro male was admitted to the Greenbrier Valley Hospital on April 21, 1962, with a history of acute malaise of four days' duration and acute pharyngitis. He complained also of other severe pruritis.

Physical examination revealed the pharynx to be injected, and a typical varicella rash over the entire body was noted. The patient arrived at the hospital during a local epidemic of chickenpox. He had not had the disease but gave a history of vaccination for smallpox.

During his hospital stay no cough, hemoptysis, chest pain nor dyspnea were manifested. On April 22, generalized rales and rhonchi de-

Submitted to the Publication Committee, January 14, 1964.

Figure 1

Figure 2

Figure 1. Diffuse nodular infiltration with mottling is visualized throughout both lung fields, with particular concentration at medial portion of right base. Diagnosis: Primary varicella pneumonia. (Figure 2) Normal x-ray taken seven days later.

veloped throughout both lung fields. A roentgenogram of the chest, taken because of these findings, showed diffuse, nodular infiltration with mottling throughout both lung fields, with particular concentration at the medial portion of the right base.

Laboratory workup on admission showed hematocrit 47 vol. per cent; WBC 10,800; hemoglobin 14.3 Gm. Schilling differential eosinophil test showed 13 stabs, 41 per cent segmented neutrophils, 39 per cent lymphocytes, and 6 per cent monocytes.

On April 27 hematocrit was 44 vol. per cent; WBC 9,100; hemoglobin 13.9 Gm. (90 per cent). Schilling differential showed 1 eosinophil, 2 stabs, 64 segmented neutrophils, 23 lymphocytes and 10 monocytes. Blood serology (April 23) was negative. Blood chemistry examination revealed glucose 114 mg./100 cc's. Blood urea nitrogen 15 mg.; total serum protein 8 Gm.; albumin 4.4 Gm.; globulin 3.6 Gm. Sedimentation rate was 30 mm. in one hour. Serum glutamic oxalacetic transaminase rate was 48 units; serum glutamic pyrovic transaminase 4 units; lactic dehydrogenase 358 units.

It is regrettable that intranuclear inclusion bodies were not sought.

A few days later the chest film cleared and the patient was discharged from the hospital, completely asymptomatic.

Summary

A case of asymptomatic primary typical varicella pneumonia in a 28-year-old negro male is reported.

The lung fields cleared in a few days and the patient was discharged from the hospital. He has remained well and is carrying on his regular work.

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Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

All scientific material appearing in *The Journal* is reviewed by the Editorial Board. Manuscripts should be mailed to The Editor, West Virginia Medical Journal, Box 1031, Charleston, W. Va. 25324.

The Practicing Physician and Community Psychiatric Efforts*

William F. Sheeley, M. D.

PERHAPS we need spend little time here on the many reasons why the trend to psychiatric care in the community is a good and wanted thing; many people already have expressed these reasons in many ways. For example, the American Medical Association, during its First Congress on Mental Illness and Health in Chicago last year, and in its official statements of policy, formally recognized the practicing physician's responsibility for psychiatric treatment offered in the community.

Psyche and Soma

More and more community general hospitals are adding psychiatric services to their spectra of treatment facilities. Practicing physicians recognize more readily than heretofore how emotions complicate the somatic illnesses of patients on medical and surgical wards; they ask psychiatrists for advice and even collaboration concerning those patients.

General medical clinics offer treatment to ambulatory patients with emotional disturbances. Not infrequently, the psychiatrists and the other physicians on the staffs of these clinics treat emotional disturbances almost interchangeably. Even medical and surgical clinics without staff psychiatrists often use psychiatric consultation and advice, also psychiatric understanding and skill, to broaden and make firm the base on which rests their treatment of somatic illness.

Congressional Action

The Congress of the United States this year passed legislation which provides pump priming funds to help launch psychiatric clinics and other treatment facilities in local communities. In each of the fifty states, the director of the state mental health program has completed a plan to discover the needs of the communities for psychiatric help and to set about providing appropriate facilities to meet those needs.

Nonmedical forces push ever more insistently for treatment of mental illness in the community; clergymen and churches assist emotionally disturbed members of their congregations; they provide either counseling or referral to physicians for treatment. Judges, law enforcement officials, school administrators and other city officials ask physicians to help with the emotional problems which complicate their daily operations. Businessmen and industrialists ask for medical help with such problems as the famous three A's: alcoholism, absenteeism and accidents.

The Author

- **William F. Sheeley, M. D., Chief, General Practitioner Education Project, American Psychiatric Association, Washington, D. C.**

Everyone Benefits

The trend toward treatment in the community is good from just about anyone's point of view. It is good from the point of view of the patient, of his family, of his employer and of others in the community who must deal with him; it is good from the point of view of the physician himself. Physicians long have been perturbed by the realization that the time dishonored method of consigning almost every psychiatric patient to the state mental hospital frequently makes him worse rather than better.

Let me emphasize that I do not deprecate the state mental hospital; I do not imply that state hospitals no longer have real and necessary functions. I do say, however, that absence of adequate treatment facilities in the community may keep a patient overlong in a state hospital and thereby may so demoralize and debilitate him that he will regain social and economic self-sufficiency only with the greatest difficulty—if, indeed, he does at all. How inconsistent we doctors are. We become enthusiastic over the principle of early ambulation after surgical procedures, and we employ elaborate equipment and procedures for physical rehabilitation, but we so rarely stress early ambulation after mental illness, and we offer comparatively little psychiatric rehabilitation in the patient's community. Yet emphasis on both of these would greatly improve the patient's chances of recovery and enhance the therapeutic effectiveness of the state hospital itself.

*Presented before a meeting of the Fort Steuben Academy of Medicine in Steubenville, Ohio, on December 10, 1963.
Submitted to the Publication Committee, December 16, 1963.

Other Advantages of Community Treatment

Another advantage of treatment in the community, furthermore, is the patient's relatively slight and brief displacement from his family. A mentally ill patient needs his family; but then so does his family need him. The briefer his absence from home the better. If a mother leaves the home but briefly, her children suffer less from the separation than they do if she stays away a long time; if a father leaves his home and job but briefly, his family suffers less from the separation and family finances remain more sound.

Yet another advantage of treatment in the community is retention of the family physician in the treatment picture. Indeed, not rarely a family physician gives a patient all the psychiatric treatment he receives, although the physician may get occasional advice from a psychiatric consultant. Sometimes family physician and psychiatrist treat a patient jointly. Even in those comparatively few cases in which the psychiatrist must initiate and direct treatment, the family physician can reassure the patient by frequent visits and can plan with him and his family for the day when the physician will resume primary responsibility for therapy.

Psychiatric Case Finding

We said at the outset that the psychiatric care in the community is essentially a medical program for which, therefore, physicians have primary responsibility. It follows, then, that practicing physicians should contribute personally to the program. Perhaps the most obvious of these many and varied contributions is the primary function of all physicians—that is, the treatment of illness. And an important aspect of the treatment of psychiatric illness or other emotional disturbance is first to discover that an illness exists and to estimate its nature and consequence. To perform this psychiatric case finding, the physician who is not a psychiatrist is better placed than the one who is. Indeed, he is better placed than any other person in the community, and for many reasons. For one thing, troubled people more readily turn to their doctor than to any other person, with the possible exception of their clergyman. The former, therefore, sees much of the frank psychiatric illness as it begins. In addition to these people who come with frank emotional disturbances are the many patients who come with ostensibly somatic symptoms which later prove to have psychiatric cause. Such patients are multitudinous. Indeed, most physicians estimate that from 40 to 70 per cent of their patients have significant emotional upset whether or not they have somatic disease also. Almost every case of somatic illness that the physician sees, furthermore, involves some degree of emotional impact on patient and family. The practicing physician can assume, therefore, that practically all of his patients have an emotional disturbance; his job is to determine the relative significance of that disturbance. That physicians so often in the past either have failed to recognize psychiatric illness or have ignored it diminishes neither their value as case finders nor their responsibility.

Diagnosis of Emotional Illness

Another important function of the practicing physician in community psychiatric efforts, a function which follows naturally once he has found a case of emotional illness, is the diagnosis of that illness. Obviously, emotional disturbance is too prevalent for the physician practicably to refer every psychiatric patient to a psychiatrist for diagnosis, nor is such referral usually necessary. Even though psychiatric diagnosis often is complicated, we can fairly expect the practicing physician to diagnose that majority of psychiatric patients whom he can recognize, and to discriminate among them those whom he needs to send to a psychiatrist for diagnosis.

Direct Treatment

The practicing physician contributes yet further to the community psychiatric effort in direct treatment of the psychiatric patient. That he should treat many patients makes sense. Surely, in those many cases in which the psychiatric disorder is intimately related to a somatic disorder, it is logical that he treat both aspects of the patient's illness simultaneously; the practicing physician with minimal psychiatric knowledge usually can treat his own patients more effectively than the psychiatrist. Even the patient with a primary psychiatric disorder and comparatively little somatic malfunction often is most practicably treated by his own physician. Many patients with a chronic neurosis or even a chronic psychosis profit more from the long-continued ministrations of their family physician who understands them, their families, and their situations than from the treatment of an unfamiliar psychiatric specialist. Many an acute psychiatric disturbance, including a not inconsiderable number of acute psychotic episodes, can be treated correctly by the patient's own physician. Furthermore, many such patients refuse treatment by a psychiatrist in the first place.

Today's physician usually treats these patients in his own office or on the medical or surgical wards of his general hospital. Growing numbers of psychiatrists and others believe, however, that the physician should treat his patient on psychiatric wards of general hospitals also and even in

state, private and other mental hospitals. Be that as it may, wherever a doctor may treat the psychiatric patient one naturally expects him to observe those ancient principles of medical ethics by seeking psychiatric advice and consultation when required, and to refer his patient to a specialist when the illness requires psychiatric skill which exceeds his own competence.

The Mental Health Team

So, much if not most of the community psychiatric effort, as least as it pertains to direct therapy of patients, will be assumed by the practicing physician as an integral part of the responsibilities of medical practice. He will be involved also in another important aspect of the psychiatric program. This aspect embraces collaboration with mental health professional persons such as ward nurses, public health officers and public health nurses, psychologists, occupational therapists, social workers, hospital administrators and vocational rehabilitation workers. He will participate more or less formally in, or with, so-called mental health teams. It may be said that a mental health team undertakes the operation of psychiatric facilities and the treatment of mentally ill persons. It deals with patients' families. It may function entirely in a mental hospital or in the psychiatric ward of a general hospital. It may function in a psychiatric or other clinic in the community. It may include the public health nurse who visits the home of former state mental hospital patients, or the homes of such patients as new mothers. When collaborating with a mental health team, a physician may be called upon to help with a program centered around a half-way house or a sheltered workshop for mental patients who are making the precarious transition from the state hospital dependency to full social independency in the community.

Contributing to the care of psychiatric patients will take the physician even further afield from the traditional practice of medicine than the mental health team. Part of the responsibility for the community psychiatric effort lies primarily with members of the community who are not physicians. This responsibility lies with leaders in legal, political, commercial, industrial, religious civic and other fields. These people must concern themselves with matters of raising funds for necessary community psychiatric facilities, of changing hostile public opinion and getting public support, and of assuring political and civic approbation. It is especially important that these leaders have the continual advice and assistance of the physician, lest they lose sight of the importance of what they are doing and their enthusiasm die, or lest they create community facilities which defeat the very purposes to which they have set themselves. One can and does look to the psychiatrist to give the community leaders much of this psychiatric guidance and advice, of course, but the psychiatrist cannot do the job alone. He needs the alliance of his nonpsychiatrist medical colleague. In many communities, furthermore, the nearest psychiatrist is so far away and his identification with the community so tenuous, that the practicing physician with minimal psychiatric understanding and skill is a much more authoritative advisor. Psychiatrists tend to cluster in cities and to avoid less populous areas. Practicing physicians, on the other hand, can be found in almost every town in the country.

Community Respect and Leadership

Another aspect of the doctor's superiority as a leader of the community psychiatric effort is his position of civic leadership and respect. He is respected naturally as an expert in medicine and therefore is expected to lead in matters medical. Since the community psychiatric effort is primarily a medical operation, then citizens logically turn to him for help and guidance. But, more than that, the doctor is also a civic leader. He enjoys a position of respect and leadership in the community, in part because he has as much formal education as most other members of the community and in part, because he usually enjoys a relatively high level of social and economic success. His professional and social activities, furthermore, bring him into regular formal and informal contact with the other professional, financial, commercial, civic and political leaders of his community. Since the community psychiatric effort depends so intimately on civic and other lay support, then, the practicing physician's civic leadership arms him particularly well to contribute to the effort. His understanding of the community and his influence in it are most important. The American Medical Association, which recognizes the influence of the doctor, quite properly reminds him repeatedly of his obligation as a citizen in addition to that as a doctor.

It is possible that some of you here have been made a little uncomfortable by the implication that you have broad, varied and grave responsibilities both to the individual psychiatric patient and to the community psychiatric effort. You are, perhaps, torn between your natural impulse to help those who call upon you and your feelings of community responsibility, and some anxious doubts about your resources of education and skill required to undertake these responsibilities in psychiatric activity.

Certainly, all of us are aware that many physicians, especially those who graduated from medical school more than a decade and a half ago, had precious little formal medical school instruction in psychiatry and that all too often even the little was of poor quality. Some medical educators and others assert, furthermore, that the very nature of the medical school student selection process tends to bring to the study of medicine those men who stress mechanical and dehumanized things at the expense of humanistic and psychological concerns.

Scope of Psychiatric Knowledge Expanded

We know also that psychiatry as a branch of medicine has in recent years expanded its scope of knowledge at a rate which forces even those of us dedicated primarily to psychiatry to expend much effort just to keep up. Even the physician who has graduated from medical school with a good command of psychiatry, therefore, soon may reach the point at which he wonders whether he dare trust his knowledge and skill any more.

Again, we know that many physicians have misconceptions of psychiatric fact. We know that many have personal attitudes which interefere significantly with their ability to use psychiatric principles, to deal with psychiatric patients, or even to work comfortably and effectively with psychiatrists. We know that many physicians either covertly or openly reject psychiatric patients, psychiatry and psychiatrists, and that they therefore tend quickly to disqualify themselves for psychiatric activities.

All of this poses problems, of course, but the problems are not insurmountable nor really so formidable as they seem. For one thing, every physician, whether he knows it or not and whether he wants to or not, uses psychotherapy in his practice every day. Sometimes, it must be sadly admitted, he does not use it ideally. Perhaps his very psychiatric ineptitude interferes with his treatment of somatic illness more than it facilitates it. Nevertheless, for better or worse, even the most outspoken rejector of psychiatry does use psychiatric therapy.

We find, therefore, as we look closely at a group of physicians, say, in a county medical society, that they have psychiatric skill of which they are aware, which they have acquired somewhere (perhaps by trial and error in their medical practice) and which they presently use daily. We find, let it be said, that they have and use psychiatric skill of which they are unaware and with no idea that they are doing so, or which they label other than psychotherapy. They have still further capability of which they are aware but so uncertain that either they distrust it or minimize its value. They have also many bits and pieces of psychiatric understanding and skill which they cannot use effectively because they have not organized those bits and pieces so as to make them usefully available.

Postgraduate Courses in Psychiatry

We see, then, that in most medical communities we have many physicians, especially those who have been in practice for several years, who have great potential value to the community psychiatric program but who for one reason or another do not contribute to it. It is to these physicians, precisely, that present nation-wide postgraduate psychiatric courses are directed. The number of these courses is increasing; the number of physicians participating in them is increasing. The quality of the courses is improving as those who offer them become more familiar with the doctors' needs and desires for psychiatric knowledge. Medical organizations collaborate with medical schools and with one another in designing and conducting the courses. It is not unusual, therefore, for a course to be sponsored jointly by a state or county medical society, a psychiatric society, a medical school, an Academy of General Practice, and other medical organizations in the locality. Those that survive are geared to the needs of the physicians who register for them. They do not emphasize the esoteric concepts of theoretical psychiatry; they are not couched in the Greek jargon which may delight the young matron over cocktails but which is of so little use at the patient's bedside; they do not strive to make the practicing physician a junior (or any other) grade psychiatrist. On the other hand, they do seek to impart knowledge by means of which he can deal more quickly, effectively and comfortably with his patients' emotional disturbances. They teach him how to use and apply some of the latest psychiatric knowledge, skill and pharmaceuticals so as best to treat his patients.

A Key Figure

The practicing physician, in short, is a key figure in the community psychiatric effort. The community depends on him to do essential things which no other person can do. More than he often realizes, he already has many special advantages and the skill needed to do these expected things, even though he may need additional postgraduate courses to augment them and to improve their applicability. Also, he has the right to expect psychiatrists and others in the community to help him prepare further to assume these responsibilities. And that, exactly, is what has brought us together here tonight.

97TH ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 20-22, 1964

Plan to Attend — Make Your Reservation . . . Now !

The President's Page

Thoughts in Retrospect

My thoughts are many and varied as I write this last "President's Page" of the year. The experience as President of the West Virginia State Medical Association has been challenging. This primarily encompassed the complex problems of organized medicine; namely (1) medical practice, (2) medico-economic, (3) socio-economic, and has required the utmost of its president, officers and members. My hope is to convey to you the important necessity of recognizing and finding the most satisfactory solutions to these continuing problems for the present and future welfare of medicine and society. Complacency cannot fill these objectives.

There exists a definite need in our State for a closer relationship between the State Medical Association and the county medical societies, the various specialty groups and the Academy of General Practice. Therefore, may I appeal to you for a united rejuvenation of purpose and effort since we are already aware of those dissipating forces existing both within and out of the profession that could fragmentate our strength. As a result of this unity there would be a greater understanding of existing problems and a more encompassing participation in programs of necessity and mutual desire. As a stimulus to this relationship, an annual conference, consisting of the officers and active committee chairmen of the State Medical Association, and the presidents and secretaries of the county medical societies, is strongly recommended. This relationship also would vitally aid more direct communication between the individual physicians, the county medical societies, and the State and American Medical Associations.

I wish to express my thanks and appreciation to the officers and members of the Council of the State Medical Association, and to the committee chairmen and members for the exceptional cooperation and fine work during the past year. I feel certain that these many long hours of work will see further fruition in years to come.

The hospitality and courtesies extended to my wife and me by the officers and members of the county medical societies has indeed been heartwarming. Mrs. Pat A. Tuckwiller, president of the Woman's Auxiliary to the State Medical Association, and the other officers and members have been most cooperative and as always functioned in an important role.

The West Virginia State Medical Association is extremely fortunate in having Mr. William H. Lively as its executive secretary, with Mr. Jerry Gould as his assistant. These men and the other members of the staff readily accomplish all tasks efficiently and I deeply appreciate their cooperation and kindness.

My successor, Dr. Albert C. Esposito, will have my complete cooperation and I trust that of the entire State Medical Association and its officers.

It has been a great honor and privilege to serve as President of the West Virginia State Medical Association during the past year.

Charles L. Goodhand

Charles L. Goodhand, M. D., President

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EDITORIALS

WE'LL SEE YOU AT THE GREENBRIER

We hope that you will take time to study the program for the 97th Annual Meeting which is printed elsewhere in this issue of *The Journal.* The members of the Program Committee are to be commended for arranging outstanding scientific sessions which undoubtedly will be of interest to all members of the West Virginia State Medical Association. The chairman is Dr. William E. Gilmore of Parkersburg, and the other members are Drs. Robert D. Crooks of Parkersburg, George F. Evans of Clarksburg, Richard E. Flood of Weirton, Seigle W. Parks of Fairmont and Clark K. Sleeth of Morgantown.

The Committee has obtained as speakers some of the nation's most prominent physicians and surgeons. Two of the speakers, Drs. Bayard Carter and Waldo E. Nelson, have appeared as guest speakers at previous annual meetings at The Greenbrier.

In addition to presenting papers at the general scientific sessions, all of the guest speakers have very graciously accepted invitations to speak before afternoon meetings of sections and affiliated societies. One of the speakers, Dr. John C. Krantz, Jr., of Baltimore, has agreed to speak at a section meeting on Friday afternoon and before a joint meeting of two other groups on Saturday afternoon.

We are fortunate to have Doctor Krantz with us as he is recognized as one of the most talented speakers in the country. He has written a book on public speaking in conjunction with Theodore McKeldin, the former Governor of Maryland, and his lectures are referred to by medical students as "the hour of charm."

There will be meetings of several committees on the Wednesday afternoon preceding the

Charles L. Goodhand, M. D.
President

formal opening of the convention on August 20. The pre-convention meeting of the Council is scheduled for 3 o'clock and the first session of The House of Delegates will be held that evening at 9 o'clock.

Dr. Norman A. Welch of Boston, President of the American Medical Association, will pay his official visit to West Virginia during the meeting and will deliver an address at the first session of the House of Delegates. Doctor Welch has been a leader in organized medicine for many years and served for four years as Speaker of the AMA House of Delegates prior to being named president elect in 1963.

Dr. Perry E. Gresham, President of Bethany College, will be among the honor guests and he will be the first speaker at the formal opening of the convention on Thursday morning. Doctor Gresham is the author of four books and has delivered lectures before groups in the United States, Canada, Mexico and the United Kingdom. His subject will be "The Physician as an Intellectual."

Dr. Charles L. Goodhand of Parkersburg, the President, will deliver his presidential address at the second session of the House of Delegates on Saturday afternoon. He has traveled hundreds of miles during the past year visiting component medical societies as well as representing the Association at numerous regional and national meetings.

The Program Committee has extended a cordial invitation to the members of the Woman's Auxiliary and guests to hear the address by Doctor Goodhand as well as the addresses by Drs. Welch and Gresham.

The Auxiliary is in charge of the entertainment program again this year and a "40th Anniversary Ball" will be held in Chesapeake Hall on Friday evening. A reception honoring the officers of the State Medical Association will be held on Saturday evening. Physicians, their wives, guests and representatives of our industrial exhibitors are cordially invited to attend both the dance and reception.

We would like to urge physicians to set aside ample time during the three-day meeting to visit the scientific and industrial exhibits which will be housed in the Exhibit Center. Exhibits will be opened each morning at 8:30 o'clock to enable physicians to make an early morning tour of the Exhibit Center before the scientific sessions are called to order. We owe much to the Industrial Exhibitors for their financial support and the representatives in attendance are always interested in discussing with physicians the new products and recent therapeutic developments.

We are happy to report that several additional firms have reserved space in the Exhibit Center this year and we hope that this is an indication that there is an increasing interest on the part of our exhibitors.

We hope that all of the members of The State Medical Association and Auxiliary who can possibly do so will plan to be with us at The Greenbrier. Reservations as of this date (July 15) have passed the 500 mark and we urge you to make your reservation immediately if you have not already done so.

We'll see you at The Greenbrier!

GRADUATE TRAINING IN THE BASIC SCIENCES

Graduate training in the basic sciences at the Master's Degree level has been offered for many years at West Virginia University School of Medicine. A beginning was made in graduate training toward the Doctor of Philosophy Degree when the School of Medicine was located in the old medical building, but not until the School was moved to the new Medical Center could this program be fully developed.

During the past two years several basic science departments (biochemistry, microbiology, pharmacology and physiology) have prepared a number of candidates for the degree of Doctor of Philosophy. This was made possible, in part at least, by Training Grants made to the School of Medicine by the National Institutes of Health.

After obtaining a bachelor's degree at least three (and more often four) years are required to earn a Ph.D. degree. Candidates are required to take advanced courses, learn research methods, write a comprehensive thesis based on original research and, of course, take searching written and oral examinations.

In the past the School of Medicine had to rely upon other schools to furnish graduate training in the basic sciences. It is gratifying that graduate training can now be offered at the School of Medicine. Residents of the State who are interested in pursuing advanced work in a number of different fields may now take their training within the borders of the State.

From the practical point of view, graduate students, especially in the third (or fourth) year of their training, can aid in the laboratory teaching of undergraduate students in the various disciplines. This helps the instructional staff and,

also, provides valuable training for the Ph.D. candidate. For a number of years the demands for individuals holding the Ph.D. degree have been greatly in excess of supply. Presently there are at least ten medical schools in the process of development, and these alone will create many new positions.

What is more important, however, are the theoretical values associated with graduate training. The training of graduate students aids in creating an intellectual environment which permeates not only the department offering such training, but other departments in the Medical Center as well. The lively and stimulating journal and research seminars, the researches in progress, the probability of discovering new facts, and the publication of scientific papers all redound credit not only to the Medical Center, but to the entire University and, indeed, to the State at large.

Man's Greatest Asset

Good health is man's greatest asset. It is the responsibility of the medical profession to assist in the development of good physical and mental health. The physician assumes a great responsibility and he develops a reputation depending on his sincerity of purpose and his relationship to his patient. By sound scientific practice he establishes a favorable status among his colleagues. By his friendly words and his satisfying treatment to his patient he gains the confidence of the public. Venerated for his acts of kindness and words of encouragement he still attempts to press a code of ethics in his profession and pour out the milk of human sympathy. Try as hard as we can to keep the perspective of the practice of medicine good, we are disturbed to learn that the confidence in the doctor by the lay people is partially fragmented. This is a stinging blow to the dedicated physicians.

During the past two or three decades medical therapy has changed with the advancement of medical science. Doctors have changed, some have become careless, charge too high a fee, show little sympathy for their patients, or being in a hurry, speak too quickly and unsympathetically. The patient is left in a freezing atmosphere. The good physician-patient relationship evaporates and the art of the practice of medicine fades.

There are many reasons for defacing the dignity of the medical profession. One of these may be modern science. Has medical science, cold as it is, overshadowed human feelings? In fact science has become a deity for some physicians. Would that such physicians read Sir Julian Huxley's "The Humanist Frame" and cogitate a while on humanism and the art of medicine? Another reason raised for an excuse for the loss of art in the practice of medicine has been the selection of all A medical students rather than the selection of some B students with high ideals, conscious of their surroundings and eager to expend a kindliness to humans. The patient, rich or poor, longs for sympathy as well as adaptation of modern scientific medicine.

The deficiencies in the practice of the art of medicine are not irrevocably lost. That they are sadly lacking in some spheres of medical practice is the fault of the doctor and the profession must correct them. To be sure the doctor must be scientific; but he must be human too. He has the right to maintain his individualism. He must prevent medical practice from being subservient to cold science, to government control or to any state organization as long as he is willing to cooperate with these agencies to effect professional dignity. By practicing the arts of medicine and improving the physician-patient relationship much can be done to restore confidence in physicians.—Clyde L. Deming, M. D., in Connecticut Medicine.

Profitless Public Service Drugs

All of the ethical drug manufacturers have on their lists one or more drugs which are of use only to a limited few. Fortunately, there is no mass market for botulism antitoxin, antirabies serum, or actinomycin D, but these are on hand for use when needed.

Such drugs are known to the trade as public service drugs and are provided after great cost of development at or below cost or free by the manfacturer who in many instances also pays the cost of emergency transportation. It is a great credit to the pharmaceutical industry that these products in limited demand are made available.

There is more involved here than the loss-leader technic or a bid for prestige. Whatever the cynics may say, we believe that what is really involved is responsibility. The companies feel it is their duty to serve the public and the medical profession in this way. This is something to remember during the present testing period for the industry.—New York State Journal of Medicine.

Portable Bulletin Board

Essentially the state journal is the tie that binds. It is the visible thread that runs from one corner of the state to the other. It is the only such ligature. It is an opinion medium for legislative, medicolegal, organizational, economic, and administrative topics. It is the officers' way of reaching the membership; and it is the members' way of letting the officers know what they—the members—think.

It is a portable bulletin board for telling the readers what's going on. Without this liaison among members, their esprit-de-corps, their feeling of professional identification, and their sense of organizational identity might well atrophy.—Henry A. Davidson, M. D., in Journal of the Medical Society of New Jersey.

Few men understand their wives. It is not fatal to enjoyment. People who are perfectly clear to each other are simply keeping things back.—Frank Moore Colby.

GENERAL NEWS

Outstanding Program Arranged For Convention, Aug. 20-22

Dr. Norman A. Welch of Boston, Massachusetts, President of the American Medical Association, heads a long list of physicians and surgeons who will appear on the program at the 97th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 20-22.

Norman A. Welch, M. D.
AMA President

Doctor Welch was elevated to the presidency of the American Medical Association at the Annual Meeting in San Francisco in June. He is a past president of the Council of the New England State Medical Societies and was elected a member of the AMA House of Delegates in 1951. He served as speaker of the House for four years, 1959-63, and was named president elect during the 1963 Annual Meeting in Atlantic City.

He will be the guest speaker before the first session of the House of Delegates on Wednesday evening, August 19. His address will be heard shortly after the House convenes at nine o'clock.

Another honor guest will be Dr. Perry E. Gresham, President of Bethany College. Doctor Gresham will deliver an address at the first general scientific session on Thursday morning, August 20. His subject will be "The Physician as an Intellectual." More than 700 persons, including physicians, their wives and guests are expected to attend the three-day meeting at The Greenbrier.

Six members of the faculty of the West Virginia University School of Medicine will participate in a symposium on "Thyroid Disease" at the third and final general scientific session on Saturday morning, August 22.

Presidential Address

Dr. Charles L. Goodhand of Parkersburg, President of the West Virginia State Medical Association, will deliver his presidential address at the second session of the House of Delegates which will be held in Chesapeake Hall on Saturday afternoon, August 22, at three o'clock.

Pre-Convention Meetings

The convention will not be formally opened until Thursday morning, August 20; however, several important committee meetings have been scheduled for Wednesday afternoon, August 19, and the pre-convention meeting of the Council will be held at three o'clock.

The registration desk will be open from 2:30 to 4:30 o'clock on Wednesday afternoon, and from 8:30 to 9:30 that evening. The desk will be open on the main floor lobby from 8:30 A.M. to 5 P.M. daily thereafter during the convention.

General Scientific Sessions

The three general scientific sessions will be held in Governor's Hall in the West Virginia Wing. Several of the afternoon meetings of sections and affiliated societies also will be held in Governor's Hall and the Mountaineer Room in the new Wing. Other meetings will be held in the Convention Unit.

15½ Hours AAGP Credit

The 97th Annual Meeting of the West Virginia State Medical Association has been authorized as acceptable for 15½ hours credit by the American Academy of General Practice.

The industrial and scientific exhibits will be housed in the beautiful and spacious Exhibit Center in the West Virginia Wing.

Motion Pictures

Dr. John J. Mahood of Bluefield is Chairman of the committee arranging the motion picture program during the three-day meeting. Sound motion pictures on appropriate scientific subjects will be shown on Thursday, Friday and Saturday mornings prior to the opening of each general session. The films will be shown in Governor's Hall.

Formal Opening of Convention Thursday Morning

The convention will be called to order by Dr. William E. Gilmore of Parkersburg, Chairman of the Program Committee, on Thursday morning, August 20, at nine o'clock. The address of welcome will be delivered by Dr. Charles L. Goodhand, President of the State Medical Association.

The first speaker on the program will be Dr. Perry E. Gresham, President of Bethany College, whose subject will be "The Physician as an Intellectual."

The meeting will then be turned over to Dr. Richard E. Flood of Weirton, who will serve as moderator for the first general session. The guest speakers and their subjects are as follows:

John M. Howard, M. D., Professor of Surgery, Hahnemann Medical College, Philadelphia, Pennsylvania. Subject: "Clinical Studies of Pancreatitis."

Eugene F. Poutasse, M. D., Devine-Poutasse Urological Group, Norfolk, Virginia. Subject: "Experiences with Renal Hypertension—Patients of all Ages."

Bayard Carter, M. D., Professor and Head of the Department of Obstetrics and Gynecology, Duke University School of Medicine, Durham, North Carolina. Subject: "Endometriosis."

Thursday Afternoon Program

Dr. J. C. Huffman of Buckhannon will preside at a meeting of the Resolutions Committee which will be held at two o'clock on Thursday afternoon.

An open meeting of the West Virginia State Society of Allergy will be held at two o'clock. Dr. Charles L. Leonard of Elkins, President of the Society, will deliver an address of welcome.

Dr. Merle S. Scherr of Charleston will serve as moderator for the scientific session which will be devoted to a "Symposium on Gastrointestinal and Food Allergy." The guest speakers and their subjects are as follows:

Maurice Kaufmann, M. D., Clinical Associate Professor of Pediatrics, The University of Kentucky College of Medicine, Lexington. Subject: "Food Allergy in Children and Adults."

Frederick A. Stenbuck, M. D., Attending Allergist, Mt. Vernon Hospital, Mt. Vernon, New York. Subject: "Gastrointestinal Allergy."

Dr. John M. Howard of Philadelphia will present a paper on "Pancreatic Cysts and Tumors" before the Section on Surgery at two o'clock. Dr. F. Lloyd Blair of Parkersburg will preside.

Doctor Blair also will preside at a meeting of the Cancer Committee which will be held at 3:30 o'clock.

House of Delegates To Meet Twice During Meeting

The Program Committee has announced that there will be two sessions of the House of Delegates during the Annual Meeting at The Greenbrier.

The first session will be convened at 9:00 o'clock on Wednesday evening, August 19, and the second session is scheduled for 3:00 o'clock on Saturday afternoon, August 22.

Albert C. Esposito, M. D.
President Elect

MCV Alumni Party

The West Virginia Chapter of the Medical College of Virginia Alumni Association will hold a Cocktail Party on Thursday evening at 6:30 o'clock. Dr. A. J. Villani of Welch is in charge of arrangements.

Second General Session Friday Morning

Dr. Robert D. Crooks of Parkersburg will serve as moderator for the second general session beginning at 9:30 o'clock Friday morning, August 21. The guest speakers and their subjects are as follows:

Waldo E. Nelson, M.D., Professor and Head of the Department of Pediatrics, Temple University School of Medicine, Philadelphia. Subject: "Fever of Undetermined Origin—Diagnostic Approach."

Dr. Perry E. Gresham

Anthony F. DePalma, M. D., Professor and Head of the Department of Orthopedic Surgery, Jefferson Medical College, Philadelphia. Subject: "Slipping of the Upper Femoral Epiphysis (Hip Problem of the Adolescent)."

John C. Krantz, Jr., Ph. D., Professor and Head of the Department of Pharmacology, University of Maryland School of Medicine, Baltimore, Maryland. Subject: "The Response of Cells to Drugs."

Friday Afternoon Program

Doctor Krantz will appear on the program before a meeting of the Section on Internal Medicine which will be held on Friday afternoon, beginning at two o'clock. He will present a paper on "Pharmacologic Approach to Coronary Artery Disease." Dr. Ralph H. Nestmann of Charleston will preside and a business meeting will follow the scientific program.

Dr. George F. Evans of Clarksburg will preside at a business meeting of the West Virginia Chapter, American Society of Internal Medicine which will be held immediately following the scientific and business sessions of the Section on Internal Medicine.

Dr. Waldo E. Nelson of Philadelphia will present a paper on "Potentials for Reducing the Incidence of Premature Births" before the West Virginia Pediatric Society at two o'clock. Dr. Warren D. Leslie of Wheeling will preside.

Dr. Donald R. Gilbert of Charleston will preside at a meeting of the Section on Urology which will be held at two o'clock. Dr. Eugene F. Poutasse of Norfolk, Virginia, will present a paper on "Partial Nephrectomy."

Dr. Bayard Carter of Durham, North Carolina, will present a paper on "Chemotherapy in Gynecologic Cancer" before the West Virginia Obstetrical and Gynecological Society at two o'clock. Dr. Frederick H. Dobbs of Charleston will preside.

"Degenerative Changes in the Cervical Spine" is the subject of a paper which Dr. Anthony F. DePalma of Philadelphia will present before a meeting of the Section on Orthopedic Surgery at two o'clock. Dr. J. Hunter Smith of Welch will preside.

Dr. James T. Spencer of Charleston will preside at a business meeting of the West Virginia Academy of Ophthalmology and Otolaryngology which will be held at two o'clock.

A meeting of the West Virginia Radiological Society will be held at two o'clock, with Dr. Harold I. Amory presiding. The speaker will be Dr. Ted F. Leigh, Professor of Radiology, Emory University School of Medicine, Atlanta, Georgia. He will present a paper on "Mass Lesions of the Posterior Mediastinum."

Dr. D. E. Greeneltch of Wheeling will preside at a meeting of the Committee on Nominations which will be held at five o'clock.

Third General Session
Saturday Morning

Dr. Clark K. Sleeth of Morgantown will serve as moderator at the third and final scientific session beginning at 9:30 o'clock on Saturday morning, August 22.

Six members of the faculty of the West Virginia University School of Medicine will present a symposium on "Thyroid Disease." The speakers and their subjects are as follows:

The 1964 Program Committee

Dr. William E. Gilmore of Parkersburg is Chairman of the Program Committee for the 97th Annual Meeting of the West Virginia State Medical Association. Other members are Drs. Robert D. Crooks of Parkersburg, George F. Evans of Clarksburg, Richard E. Flood of Weirton, Seigle W. Parks of Fairmont and Clark K. Sleeth of Morgantown. They were appointed by the President, Dr. Charles L. Goodhand of Parkersburg.

Convention Timetable

General scientific sessions daily beginning at 9:00 A. M. on Thursday, and 9:30 A. M. on Friday and Saturday.

House of Delegates: First Session, Wednesday evening at 9 o'clock, and Second Session, Saturday afternoon at 3 o'clock.

Scientific and Industrial Exhibits (Exhibit Center): Open from 8:30 A. M. until 3:30 P. M. on Thursday and Friday, August 20 and 21; and from 8:30 A. M. to 1 P. M. on Saturday, August 22.

George G. Green, M. D., Associate Professor of Radiology. Subject: "Radiological Aspects of the Diagnosis and Treatment of Thyroid Disease."

John E. Jones, M. D., Assistant Professor of Medicine. Subject: "Iodine Metabolism and Familial Goiter."

Paul C. Desper, M. D., Fellow in Medicine, and Frank E. Medford, M. D., Resident in Medicine. Subject: "Review of West Virginia University Hospital Experience with I^{131} Treatment of Hyperthyroidism."

Edmund B. Flink, M. D., Professor and Chairman, Department of Medicine. Subject: "Hashimoto's Disease."

Dr. Victor M. Napoli, Assistant Professor of Pathology, will lead a panel discussion on "Cancer of the Thyroid and Hashimoto's Disease." Doctor Napoli will present case material for the panel discussion and participants will include the West Virginia University faculty members and out-of-state guest speakers.

Saturday Afternoon Meetings

Drs. W. H. Rardin of Beckley and Carrel M. Caudill of Charleston will preside at a joint meeting of the West Virginia Society of Anesthesiologists and the Section on Neurology, Neurosurgery and Psychiatry which will be held at 1:30 o'clock on Saturday afternoon. The speaker will be Dr. John C. Krantz, Jr., of Baltimore, whose subject will be "A Round Trip Journey from Anesthesia to Psychiatry Via the Fluorinated Ethers."

A business meeting of the West Virginia Association of Pathologists will be held at 1:30 o'clock, with Dr. Grover B. Swoyer of Charleston presiding.

Second Session of the House of Delegates

Dr. Charles L. Goodhand, Parkersburg, the President, will preside at the second and final session of the House of Delegates which will be convened at three o'clock on Saturday afternoon.

Dr. Albert C. Esposito of Huntington, the President Elect, will be installed as President during the business session. Other officers for 1964-65 also will be elected and installed.

Dr. Charles L. Goodhand will deliver his Presidential Address at this session of the House.

Dr. O. W. Ladwig of Wilsonburg, Harrison County, who was named as West Virginia's "General Practitioner of the Year," will be introduced, together with Carl E. Nichols of Glenville and Byron L. Van Pelt of Bethany, the recipients of the State Medical Association's 1964 four-year scholarships to the West Virginia University School of Medicine.

No Convention Registration Fee

No registration fee will be assessed against either members or guests in connection with the 97th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 20-22, 1964.

Nominating Committee To Meet On Friday, August 21

The Committee on Nominations of the State Medical Association will meet at five o'clock on Friday afternoon, August 21, during the Annual Meeting at The Greenbrier.

The Committee will consider and recommend to the House of Delegates prior to the election of officers, at its final session, its nominee for the office of president elect, vice president, treasurer and the American Medical Association delegate and alternate.

The current councilor at large, Dr. D. E. Greeneltch of Wheeling, will serve as chairman and the other members are the following senior councilors in point of service from each councilor district: Drs. Paul P. Warden of Grafton, Charles L. Leonard of Elkins, Richard V. Lynch, Jr., of Clarksburg, Richard W. Corbitt of Parkersburg, Ward Wylie of Mullens, and William B. Rossman of Charleston.

The By-Laws also specify that nominations may be made from the floor for the above-mentioned offices.

Dance on Friday Evening

The Woman's Auxiliary to the West Virginia State Medical Association will sponsor a 40th Anniversary Ball in Chesapeake Hall on Friday evening, August 21, beginning at 10 o'clock. Music will be furnished by "The Townsmen."

Cocktail Party on Saturday Evening

A cocktail party and reception honoring the officers of the West Virginia State Medical Association will be held on the Chesapeake Hall Terrace on Saturday evening, August 22, from 6:30 to 7:30 o'clock. All members of the Association and the Auxiliary, their families, representatives of the industrial exhibits, and guests are invited to attend.

Prizes to the winners of the Golf Tournament will be awarded at the Cocktail Party.

Industrial and Scientific Exhibits

More than 50 interesting and informative industrial and scientific exhibits will be housed in the beautiful and spacious Exhibit Center.

The exhibits will be open daily from 8:30 A. M. to 3:30 P. M. Physicians, members of the Auxiliary and guests are invited to talk with the representatives of various drug and accessory houses throughout the meeting.

Heavy Registration

The number of reservations for rooms at The Greenbrier during the annual meeting has passed the 500 mark. It is anticipated that more than 700 persons will be in attendance.

W. Va. Heart Association Schedules Annual Meeting in Huntington

The annual meeting of the West Virginia Heart Association will be held at the UpTowner Inn in Huntington, September 3-4. Dr. Otis G. King of Bluefield, the president, has extended a cordial invitation to all physicians practicing in West Virginia to attend.

Otis G. King, M. D.

George E. Wakerlin, M. D.

The two-day meeting will open on Tuesday evening, September 3, with a meeting of the Association's board of directors and the annual election of officers. In addition to Doctor King, other officers are as follows:

Dr. A. C. Thompson of Elkins, president elect; Dr. Albert D. Kistin of Beckley, vice president and chairman of the program committee; Mrs. F. Taylor Easley of Bluefield, secretary; and Mrs. Mary Helen Thompson of Charleston, treasurer.

Doctor Thompson will preside at the scientific session on Friday which will have as its theme, "A Day of Diagnosis." The speakers and their topics will be as follows:

"Fundamentals of Cardiac Roentgenology."—Benjamin Felson, M. D., Cincinnati.

"Cardiac Auscultation."—Alan M. Weintraub, M. D., Washington, D. C.

"Electrocardiography."—Robert O. Brandenburg, M. D., the Mayo Clinic, Rochester, Minnesota.

Both Doctor King and Doctor Thompson will speak at the annual membership luncheon on Friday. Nearly 40 members will be elected to the Association's Board of Directors at that time.

Dr. George E. Wakerlin of New York City, Medical Director of the American Heart Association, will be the guest speaker at the annual banquet on Friday evening.

He assumed his present post in 1958 and since July, 1959, he has been Professor of Clinical Physiology at the College of Physicians and Surgeons of Columbia University. Previously he served for more than 20 years as Professor and Head of the Department of Physiology at the University of Illinois College of Medicine in Chicago.

Doctor Wakerlin has devoted much of his time in the past 25 years to research, especially in the field of hypertension. Among his many contributions was the discovery, with his associates, of antirenin, a pressure raising enzyme produced by the kidney.

Maternal and Infant Care Program In Monongalia County Area

West Virginia has received grants totaling $130,537 from the U. S. Children's Bureau for two special projects to offer improved services to mothers and children. State Director of Health Dr. N. H. Dyer, writing in his weekly State of the State's Health, announced that $98,537 of the grant will apply to the first year's operation of a program for comprehensive maternal and infant health care in the Monongalia County area. The remaining $32,000 will be used to purchase a mobile medical examination clinic similar to a unit purchased in 1962.

The Monongalia County program will be launched as a cooperative venture of West Virginia University, the Monongalia County Medical Society, Monongalia County Health Department and the State Department of Health.

Designed for Medically Indigent

Designed specifically for medically indigent mothers and their newborn infants, the program will provide prenatal clinic services, special care for medical complications of pregnancy, consultation services for mothers and newborns on a referral basis, and special care for infants up to one year of age having medical complications incident to birth. Additional services for families of mothers and children eligible for care under the plan include home nursing visits, nutritional counseling, transportation assistance, homemaker services and social service.

Financing of 75 per cent of costs was made possible through the 1963 Maternal and Child Health and Mental Retardation Planning amendments to the Social Security Act. Doctor Dyer said sufficient federal participation could be expected for extension of the program to other areas of the State if local communities can find necessary matching funds. In Monongalia County, the matching requirement of 25 per cent was met by a cooperative effort of West Virginia University and the Monongalia County Health Department.

School Surveys Popular

Delivery of the new mobile clinic is expected in time to be utilized in school health programs during the 1964-65 term. Both units will be assigned primarily to a county-by-county health survey in schools now being conducted by the Division of Maternal and Child Health, in cooperation with practicing physicians, local schools, county health departments and community groups.

Surveys already have been completed of first-grade pupils in Clay and Summers counties. The popularity of these surveys is evidenced by the high level of cooperation received from the counties in organizing the surveys and participation of more than 90 per cent of the pupils.

The need for the program is underscored by the high incidence of both acute and chronic conditions found. In Clay County, 275 abnormalities were uncovered among 170 students examined. First graders in Summers County registered 197 abnormal conditions among 334 students.

Doctor Holroyd Reelected Secretary Of Aces and Deuces

Dr. Frank J. Holroyd of Princeton was reelected to a sixth consecutive term as secretary-treasurer of the Aces and Deuces organization at the annual breakfast meeting held at the Fairmont Hotel in San Francisco on June 23. The meeting was attended by more than 180 persons.

Dr. Lindsay E. Beaton of Tucson, Arizona, was elected president, succeeding Dr. Joseph D. McCarthy of Omaha, Nebraska.

Other West Virginians attending the meeting were Mrs. Frank J. Holroyd, Dr. and Mrs. Charles L. Goodhand of Parkersburg, Dr. and Mrs. Pat A. Tuckwiller, Dr. and Mrs. John W. Hash, and Dr. and Mrs. Hunter Boggs, all of Charleston, and Dr. Clark K Sleeth of Morgantown.

The Aces and Deuces is a social organization composed of AMA delegates and alternates from state medical associations and societies which have one or two members in the House of Delegates.

An Aces and Deuces luncheon honoring AMA officers and members of the House of Delegates will be held during the clinical session at Miami Beach, Florida.

Medical Meetings, 1964

The following is a partial list of national, state and district medical meetings scheduled for 1964:

Aug. 20-22—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 4—W. Va. Heart Assn., Huntington.
Sept. 10—Cabell County Symposium, Huntington.
Oct. 1—Rural Health Conf., Jackson's Mill.
Oct. 11-15—ACCP Congress, Mexico City.
Oct. 23-25—Potomac-Shenandoah Valley PG Institute, Martinsburg.
Oct. 23-25—American Heart Assn., Atlantic City.
Nov. 16-19—Southern Medical, Memphis, Tenn.
Nov. 29-Dec. 2—AMA Clinical Meeting, Miami Beach.

Daywood Art Gallery In Lewisburg

Physicians, their wives and guests attending the annual meeting at The Greenbrier in August have been extended a cordial invitation to visit the Daywood Art Gallery in nearby Lewisburg. The Gallery is open daily from 1:00-5:00 P. M. Admission is free.

Thousands of visitors from this country and abroad have visited the Gallery since its opening in 1951. It was established by Ruth Woods Dayton in memory of her husband Arthur Spencer Dayton, an attorney and collector of art and rare books.

Exhibited in a homelike atmosphere of English and American antique furnishings are 75 paintings and 145 etchings by nationally recognized artists.

Luncheon for Past Presidents

A luncheon honoring past presidents of the West Virginia State Medical Association will be held at The Greenbrier on Thursday, August 20, during the 97th Annual Meeting.

Dr. L. J. Pace of Princeton, immediate past president, will preside. Twenty-four living past presidents have been invited to attend.

Dr. R. R. Brown of Romney Defending Golf Champion

The winner of the Medical Golf Tournament which will be held in connection with the 97th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 20-22, will receive a trophy offered by the Hospital and Physicians Supply Company of Charleston.

Dr. R. R. Brown of Romney is the defending champion. He shot a 73 in 1963 to win the title. Dr. Joseph T. Mallamo of Fairmont, the winner of six titles in the past eight years, finished one stroke off the pace with a 74.

Other low gross scorers were Drs. Kenneth E. Owen of Marietta, Ohio, 75; R. A. Crawford of Charleston, 76; William C. Morgan, Jr., Charleston, 79; Jack Leckie, Huntington, 82; and George A. Curry, Morgantown, 83.

Dr. Joseph A. Smith of Dunbar, Chairman of the Golf Committee, said that physicians participating in the tournament will pay an entrance fee of $5, payable at the time they register to play in the tournament. There will be several prizes in addition to the championship trophy.

Physicians may engage in tournament play both mornings and afternoons during the three-day meeting. Participants are to inform the starter when they begin their official tournament round. All tournament play must be completed by four o'clock on Saturday afternoon, August 22.

Regional GP Symposium Held At The Greenbrier

A Symposium on Medicine and Surgery, sponsored by the West Virginia Chapter of the American Academy of General Practice with the cooperation of Eli Lilly and Company, was held at The Greenbrier in White Sulphur Springs on June 28.

Four members of the faculty of the West Virginia University School of Medicine presented papers during the scientific session.

The speakers and their subjects were as follows:

A. C. Edmundowicz, M. D., Assistant Professor of Medicine, "Heart Block."

Thomas D. Darby, M. D., Associate Professor of Pharmacology, "Drug Therapy of Ischemic Heart Disease."

Paul Davidson, M. D., Instructor in Medicine, "The Fallacy of the Serum Cholesterol."

Richard A. Currie, M. D., Assistant Professor of Surgery, "The Management of Thrombo Embolism."

Dr. Norman A. Welch Installed As President of AMA

Dr. Norman A. Welch of Boston was installed as President of the American Medical Association during the 113th Annual Convention in San Francisco, June 21-25. He had been named President Elect at the 1963 meeting in Atlantic City.

The new president will be among the honor guests at the 97th Annual Meeting of the West Virginia State Medical Association at The Greenbrier, August 20-22. He will deliver an address at the first session of the House of Delegates on Wednesday evening, August 19.

Dr. Donovan F. Ward of Dubuque, Iowa, Vice President of the Association, was named President Elect at the concluding session of the House of Delegates on June 25. He will be installed as President at the 1965 Convention in New York City.

Dr. Carlton Wertz of Buffalo, New York, was elected Vice President, and Drs. Milford O. Rouse of Dallas and Walter C. Bornemeier of Chicago, were reelected speaker and vice speaker of the House of Delegates, respectively.

Dr. Robert C. Long of Louisville was reelected to the Board of Trustees for a three-year term, and Dr. Alvin J. Ingram of Memphis was elected to a three-year term. Doctor Ingram replaces Dr. R. B. Robins of Camden, Arkansas.

Dr. Charles C. Smeltzer of Knoxville was named a member of the Judicial Council and Drs. William P. Longmire of Los Angeles and William A. Sodeman of Philadelphia were named to the Council on Medical Education.

Dr. Willard A. Wright of Williston, North Dakota, was reelected a member of the Council on Medical Service. Dr. John Rumsey of San Diego also was named a member of the Council.

Dr. William A. Hyland of Grand Rapids, Michigan, was reelected to the Council on Constitution and By-Laws.

State Delegates Attend Meeting

Drs. Charles A. Hoffman of Huntington and Frank J. Holroyd of Princeton, AMA Delegates, represented the State Medical Association at the meeting in San Francisco.

Dr. Charles L. Goodhand of Parkersburg, President of the State Medical Association, also attended the meeting.

Summary of the San Francisco Meeting

The following summary of the San Francisco meeting was prepared for publication by Dr. F. J. L. Blasingame, Executive Vice President of the American Medical Association:

Tobacco and health, human rights, physician-hospital relations, continuing medical education, the cost of medical care, and federal subsidization of prepayment plans and health insurance companies were among the major subjects acted upon by the House of Delegates.

The 1964 AMA Distinguished Service Award was won by Dr. Irvine H. Page, director of research of the Cleveland Clinic, for his investigation of cardiac, vascular and renal disease.

Final registration figures reached a grand total of 49,437, including 14,229 physicians.

Tobacco and Health

The House approved a strong stand on tobacco and health by calling cigarette smoking "a serious health hazard." This action was taken after the reference committee on Public Health and Occupational Health considered 10 resolutions and a Board of Trustees report on the subject and heard considerable testimony.

In adopting a four-point reference committee report, the House said "the American Medical Association is on record and does recognize a significant relationship between cigarette smoking and the incidence of lung cancer and certain other diseases."

It urged that programs be developed to disseminate vital health education material on the hazards of smoking to all age groups through all means of communication. The House also recognized the contribution of the Surgeon General's Committee in its comprehensive report. And it emphasized that a joint committee of the AMA and the National Education Association already has adopted a resolution urging elementary and secondary schools to include programs on smoking and health in their health education curricula.

The House further recommended that the AMA pamphlet, "Smoking: Facts You Should Know," should be modified "in the light of accumulating knowledge."

Finally, the House said that the delegates and the Board of Trustees "should take great pride in the establishment of the research program on tobacco and health that is being carried out by the AMA Education and Research Foundation."

In adopting the report of the AMA-ERF the House called attention to the following statement:

"The Board of Directors of AMA-ERF and the Board of Trustees of the AMA were clearly aware of the possibility of criticism in accepting this grant (10 million dollars from several tobacco companies). But against that possibility they weighed the potential benefits to the public who will continue to smoke and concluded that the risk was insignificant by comparison. The only hope of minimizing the hazards of smoking lies in research which points to the course that the AMA as well as others must take."

Human Rights

On the major issue of human rights the House declared itself "unalterably opposed to the denial of membership, privileges and responsibilities in county medical societies and state medical associations to any duly licensed physician because of race, color, religion, ethnic affiliation, or national origin."

In addition, the House called "upon all state medical associations, all component societies, and all individual members of the AMA to exert every effort to end every instance in which such equal rights, privileges and responsibilities are denied."

The House also accepted a report from the Board on the liaison committees of the AMA and the National Medical Association. This report reviewed the history of the committees and noted that "great progress has been made voluntarily. More progress can reasonably be expected in the immediate future, especially if the committees are permitted to continue on a constructive, cooperative basis. This requires effort, but more importantly, good will and the desire to eliminate problems."

Physician-Hospital Relations

Conclusions and recommendations in a significant and extensive report on physician-hospital relations were adopted by the House. Prepared by the Council on Medical Service's Committee on Medical Facilities, the report stresses "the imperative need for the medical profession to assume responsibility for the quality, continuity and availability of professional services and for the coordination of these services with the other essential supportive aspects of health care."

The report's recommendations are designed to serve as guidelines for physicians in meeting the problems involved in the changing patterns of care such as: appointment of salaried chiefs of staff; appointment of salaried heads of clinical departments; appointment of salaried directors of medical education; employment of salaried physicians for outpatient and emergency departments; use of salaried physicians to provide care ordinarily provided by interns and residents; and utilization of closed-panel prepayment medical care programs by hospitals.

The report also includes a review of the development of AMA's policy on physician-hospital relations, a study of the relation of policy to actual practice, and an investigation of the factors influencing change—including graduate education, medical finance, expansion of hospital functions and regulation of medical care.

Continuing Medical Education

Authorization was made by the House to establish an AMA-sponsored survey and accreditation program in continuing medical education. In the program attention will be concentrated on institutions and organizations offering courses rather than on individual courses, and appraisal of an institution's or organization's program will be carried out only at its request.

Eventually, approved institutions or organizations will be so designated in the Council's annual lists of "Continuing Education Courses for Physicians," and when all institutions which wish to list their courses have had the opportunity to be considered for approval, only courses of approved institutions and organizations will be included in the annual list. Programs will be surveyed by a Review Committee on Continuing Medical Education.

Cost of Medical Care

A four-volume report of the AMA Commission on the Cost of Medical Care was received by the delegates, and the House concurred with the Board of Trustees that the conclusions and recommendations of the Commission will be studied and a report will be made to the House for its consideration at the 1964 Clinical Convention.

The four volumes include a General Report on factors involved in medical care costs, a full report on "Professional Review Mechanisms," another on "Significant Medical Advances," and on "Changing Patterns of Hospital Care."

In its report the Board said that the Commission "is aware that its efforts will not result in a magic reduction in the price of medical and hospital services. It does believe, however, that its study has produced a considerable amount of new and relevant information which will serve as a basis for better understanding by the public and the medical profession of this complex subject."

These West Virginia physicians and their wives attended a breakfast meeting of the Aces and Deuces organization on June 23 at San Francisco during the 113th Annual Meeting of the American Medical Association. Left to right, Dr. Frank J. Holroyd of Princeton, Dr. John W. Hash and Dr. Hunter Boggs of Charleston, Mrs. Holroyd, Mrs. Boggs, Mrs. Hash, Mrs. Pat A. Tuckwiller of Charleston, Mrs. Charles L. Goodhand of Parkersburg, and Drs. Tuckwiller and Goodhand.

Reaffirmed the AMA policy favoring federal grants for "bricks and mortar"—funds for construction and renovation of medical schools, hospitals, related institutions, and mental health centers—but urged that the "advantages and desirability of mulitple source financing be kept clearly in mind." The House also was informed by the Board that it is appointing a commission to conduct a broad study of the role of federal support of medical research.

Other Actions

The House went on record as opposing federal subsidization of prepayment plans and health insurance companies, and it asked for an AMA study of the development of state programs which utilize prepayment plans or health insurance companies in the implementation of state programs of medical aid to the aging under the Kerr-Mills law.

A proposal to poll all AMA members concerning compulsory Social Security for self-employed physicians was rejected by the House. In addition, the House concurred with the reference committee in opposing polls of the membership on issues of "great or even moderate importance" because the House members express the majority sentiments of their constituents on all questions coming before the House.

An expanded program on medical ethics was endorsed by the House. The program will be designed to educate physicians and the public on what medical ethics means to them and how medical ethics affects them. The Judicial Council, working with the Board of Trustees, will determine the means by which this expanded program is to be implemented.

Approval was given to a change in the By-Laws to allow the House to set the hour and day of election of AMA officers at the Annual Convention. This was adopted early in the House session and made it possible to have the nominations on Wednesday afternoon and the elections on Thursday morning.

A three-point communications program designed to improve the public relations position of the medical profession was endorsed by the House on recommendation of the AMA Committee on Communications. The program includes a redoubling of efforts by county and state societies, closer liaison with media personnel and prompt information to state societies on AMA news releases and testimony.

Miscellaneous Actions

In considering a wide variety of resolutions and reports, the House also:

Approved the creation of the Section on Allergy on recommendation of the Board of Trustees.

Approved a comprehensive inquiry of the causative factors for the sharp increase in syphilis and gonorrhea and urged the AMA to "take leadership in educational and research measures designed to control and eliminate syphilis."

Okayed a national conference on areawide planning of hospitals and related health facilities, to be sponsored under the auspices of the AMA.

Agreed to continue and broaden studies on the problems of unwed mothers, illegitimacy and other related matters and to develop positive preventive programs.

Supported a position statement on protecting children against physical abuse and called for legislative guidelines to the states relative to legislation on this matter.

Asked the Board of Trustees to investigate establishment of a wire communications system between AMA headquarters in Chicago and offices of state medical associations.

Referred to the Council on Medical Service a resolution condemning the practice by some hospitals of adopting constitutions which deny staff privileges to physicians not eligible or certified by specialty bodies or societies.

Agreed with the Board that a forum for representatives of national medical specialty societies and the American Academy of General Practice be held in Chicago on November 1, 1964.

Approved a resolution calling for publication of the proposed nominees for standing committees (councils) of the House, with the list to be submitted in advance of the Annual Convention, preferably in the House of Delegates Handbook.

Recommended that the Board of Trustees use the talents of Dr. Edward R. Annis, immediate past president, and other qualified spokesmen for medicine with appropriate remuneration.

Asked the Committee on Insurance and Prepayment Plans of the Council on Medical Service to consider a revision of simplified health insurance claims forms.

Recommended that the Board of Trustees approve the establishment of an ad hoc study on family practice as proposed by the Council on Medical Education.

Agreed with the change of name of the Council on Medical Education and Hospitals to the Council on Medical Education.

Requested clarification of the ethical and legal limitations of physicians participating in court-ordered, pre-trial psychiatric examinations.

Urged the AMA to continue its vigorous opposition to tax regulations discriminating against "professional associations" and "professional corporations," and its support of legislation which seeks to provide tax equality with business corporations for "professional associations" and "professional corporations."

Opening Session

Dr. Edward R. Annis of Miami, outgoing AMA president, told the special Sunday afternoon opening session that a greater effort is needed in the areas of continuing medical education and health education programs. He also urged state and county medical associations to bolster their paid executive personnel to help carry out local, state and national projects.

Doctor Annis called for an increase in AMA dues and later the House referred the question of a dues increase to the Board of Trustees for study and for a report at 1964 Clinical Meeting in Miami. Honored at the opening session were the presidents of state and

territorial medical associations and a number of special AMA guests from national organizations.

At the Monday session awards announced were the AMA Scientific Achievement Award to Prof. Rene Jules Dubos, Ph. D., of the Rockefeller Institute, New York City, and the Joseph Goldberger Award in Clinical Nutrition to Dr. William J. Darby of Vanderbilt University School of Medicine, Nashville.

Inaugural Ceremony

Doctor Welch, in his inaugural address Tuesday night, said that medicine must be united if it is "to serve the public in the future to the high degree that it has in the past." He stressed that American physicians must be "standing strong and firm with a heart and a conscience turned to public need, with a respect for the rights and privileges of the individual, and with an abiding faith in our free competitive system of medical practices."

In keeping with Doctor Welch's Address, "Unity in Medicine," presidents or their representatives from 29 medical specialty organizations were honored guests at the ceremony.

The Distinguished Service Award was presented to Doctor Page and the Scientific Achievement Award was given to Doctor Darby.

Wednesday Session

Speaking at the Wednesday session, Doctor Welch pointed up the growing alliance between medicine and research—an alliance rooted in truth, knowledge and the freedom to search them out. He called these "the greatest assets available for human development and human well-being." Doctor Welch also enumerated the important projects of the AMA in the past year such as mental health, continuing medical education, tobacco and health, and AMA-ERF, the Institute of Biomedical Research.

Mrs. Sutter Named President Elect Of AMA Auxiliary

Mrs. Pat A. Tuckwiller of Charleston, President of the Woman's Auxiliary to the West Virginia State Medical Association, and Mrs. George A. Curry of Morgantown, the president elect, were among West Virginians who attended the 41st Annual Meeting of the Woman's Auxiliary to the American Medical Association in San Francisco, June 21-25.

Mrs. William H. Evans of Youngstown, Ohio, was installed as president of the organization, succeeding Mrs. C. Rodney Stoltz of Watertown, South Dakota. Other new officers are as follows:

Mrs. Richard A. Sutter of St. Louis, Missouri, president elect; Mrs. Asher Yaguda, Newark, New Jersey, first vice president; Mesdames James L. McCartney of Garden City, New York, Earl W. Roles of Louisville, Samuel Gendel of Fullerton, California, and W. A. Merritt of Rochester, Minnesota, regional vice presidents; Mrs. Howard Liljestrand of Honolulu, Hawaii, constitutional secretary; Mrs. Karl F. Ritter of Lima, Ohio, treasurer; and Mesdames John B. Farley of Pueblo, Colorado, R. C. L. Robertson of Houston, Texas, and John M. Chenault of Decatur, Alabama, directors.

More Than 60 Attend 15th Annual B-R-T Postgraduate Session

More than 60 members and guests attended the 15th Annual Postgraduate Meeting of the Barbour-Randolph-Tucker County Medical Society which was held at the Elks Country Club near Elkins on Thursday, June 18.

Dr. Charles L. Leonard of Elkins served as the moderator for a "Symposium on Alcoholism." The speakers and their subjects were as follows:

James A. Thompson, M. D., Clarksburg, "Toxic Effect of Alcohol on the Human Body."

William Jones Brown, M. D., Psychiatrist, Staunton Clinic, Pittsburgh, "The Personality and Behavior of the Alcoholic."

Joseph Chambers, M. D., Physician-in-Charge, Alcoholic Unit, District of Columbia General Hospital, Washington, "The Family Physician and His Alcoholic Patient."

W. T. Dixon Gibbs, Executive Director, Baltimore Area Council on Alcoholism, Baltimore, "The Medical Profession and Alcoholics."

Mr. Donald R. Dancy, Director of the Alcoholic Division of the State Department of Mental Health, presented a brief resume of the facilities now available at Spencer State Hospital for rehabilitation of the "dried out" alcoholic.

Mr. Charles W. Gooden of New York City was guest speaker at the banquet. He discussed "Alcoholism and the A. A."

Drs. F. W. and Joseph T. Mallamo of Fairmont had the first and second low-gross scores in a golf tournament held in connection with the one-day meeting.

11 Physicians Licensed by MLB To Practice in State

The Medical Licensing Board licensed 11 physicians by reciprocity at a meeting held at The Capitol in Charleston, April 27, 1964. The following physicians were licensed:

Auerbach, Sidney, St. Clair Shores, Michigan
Burton, Zeb Carson, Jr., Atlanta, Georgia
Campbell, Edgar Thrall, Hagerstown, Maryland
Graham, Robert H., Morgantown
Hahn, Adam William, Man
Heilman, Elwood Hess, Charleston
Johnson, Stancil E. D., Morgantown
Meyers, Harold Russell, Williamson
Proctor, Herbert D., Decatur, Georgia
Robinson, Ralph Rollin, Middlesboro, Kentucky
Teets, Harry Jackson, Weirton

Dr. Ross P. Daniel Named Director Of Raleigh County Health Dept.

Dr. Ross P. Daniel of Beckley has become the full-time director of the Raleigh County Health Department. He assumed his duties on July 1 after holding the post on a part-time basis for 33 months.

A native of Beckley, Doctor Daniel received his M. D. degree in 1924 from the University of Tennessee College of Medicine and has practiced for 40 years in Raleigh County.

President of AMA Auxiliary To Attend Annual Meeting

More than 200 wives of physicians are expected to attend the 40th Annual Meeting of the Woman's Auxiliary to the West Virginia State Medical Association which will be held at The Greenbrier in White Sulphur Springs, August 20-22.

Mrs. Pat A. Tuckwiller of Charleston, the President, will preside at the three-day meeting which will be held in conjunction with the 97th Annual Meeting of the State Medical Association.

Mrs. William H. Evans of Youngstown, Ohio, who was installed as President of the Woman's Auxiliary

Mrs. Pat A. Tuckwiller
President

to the American Medical Association in June at San Francisco, will be among the guest speakers and will deliver the keynote address at the opening session on Thursday morning, August 20.

Pre-Convention Meetings

Mrs. Tuckwiller will preside at a pre-convention meeting of the Executive Board which will be held at three o'clock on Wednesday afternoon, August 19, the day preceding the formal opening of the convention.

A cordial invitation has been extended to members of the Auxiliary to attend the first session of the Association's House of Delegates which will be held that same evening. Dr. Norman A. Welch of Boston, President of the American Medical Association, will be the guest speaker.

Bethany President Guest Speaker

Physicians, wives and their families are invited to hear an address by Dr. Perry E. Gresham, President of Bethany College, at the Association's first general session in Governor's Hall at nine o'clock on Thursday morning.

General Business Sessions

The Auxiliary's general business sessions will be held on Thursday and Friday mornings, leaving the afternoons free for committee meetings and participation in the golf and bridge tournaments arranged in connection with the meeting.

Mrs. Tuckwiller will preside at the opening session on Thursday morning and the invocation and pledge of loyalty will be given by Mrs. Robert R. Pittman of Marlinton.

The agenda at the first session will include reports of convention committees and recommendations of the Executive Board. Reports of County Auxiliary presidents also will be received together with reports of the officers and the standing and special committees.

Address by Mrs. William H. Evans

The guest speaker at the first session will be Mrs. William H. Evans, the AMA Auxiliary President, who will deliver the keynote adress.

Mrs. Evans, an Auxiliary member for twenty years, has served her county and state organizations in many capacities. She was president of the Ohio State Auxiliary in 1956-57, and on the national level, she served on the Resolutions Committee in 1957, as Regional Vice President, 1957-58, as Director, 1958-60, and as Constitutional Secretary, 1961-63.

She is a native of Youngstown and before her marriage in 1942 to Doctor Evans, an ophthalmologist and otolaryngologist, she was employed as an office manager, buyer, and jewelry designer. She also studied at Case School of Applied Science, University of California and the American Gemological Institute.

Election of Officers on Friday

The annual past president's breakfast will be held at eight o'clock on Friday morning, with Mrs. Howard G. Weiler of Wheeling, immediate past president, presiding. Mrs. Tuckwiller will preside at the second general session which will be held at 9:30 A.M. on Friday. In addition to receiving reports of various committees, new officers will be elected for the coming year following a report of the nominating committee.

The first speaker at the Friday morning session will be Dr. Charles L. Goodhand of Parkersburg, President of the West Virginia State Medical Association.

Mr. James Foristel, Legislative Representative for the American Medical Association in Washington, will also appear on the Friday program.

Mrs. Evans will install the newly elected officers. The presentation of the president's pin and gavel will be made by Mrs. Pat A. Tuckwiller to Mrs. George A. Curry of Morgantown, the incoming president. The presentation of the past president's pin to Mrs. Tuckwiller will be made by Mrs. Howard G. Weiler.

Address by Mrs. George A. Curry

Mrs. George A. Curry, who will be installed as President, will deliver her inaugural address following the installation ceremonies.

40th Anniversary Ball Planned

The Woman's Auxiliary is in charge of the entertainment program for the convention. The feature entertainment will be the 40th Anniversary Ball on Friday evening in Chesapeake Hall.

Post-Convention Conference

Mrs. George A. Curry, the incoming president, will preside at a post-convention conference which will be held at 10 A. M. on Saturday, August 22. This meeting will be the final item of business on the formal program.

Second Session of the House of Delegates

The second session of the Association's House of Delegates will be held at three o'clock on Saturday afternoon. Auxiliary members are cordially invited to attend both sessions of the House of Delegates.

The second session will feature the annual Presidential Address by Dr. Charles L. Goodhand of Parkersburg. There also will be the introduction of West Virginia's "General Practitioner of the Year," and the two recipients of the State Medical Association's 1964 four-year scholarships to the West Virginia University School of Medicine. The business session will conclude with the election of officers for the coming year.

A cocktail party and reception honoring the officers of the West Virginia State Medical Association will be held on the Chesapeake Hall Terrace from 6:30 to 7:30 that evening. All members of the Auxiliary, State Medical Association, exhibitors and guests are invited to attend.

Convention Committee

Mrs. J. A. B. Holt and Mrs. A. B. Curry Ellison, both of Charleston, are co-chairmen of the convention. They were appointed by the President, Mrs. Pat A. Tuckwiller.

Graduate Student to Conduct Survey Among State Physicians

Miss Anna Louise Miller, a graduate student at Marshall University, has undertaken a study to determine the extent West Virginia physicians participate in community affairs.

Miss Miller explained the proposed project in a letter to Dr. Charles L. Goodhand of Parkersburg, the President, and he discussed the proposal at a meeting of the Council on May 3. The Council approved the project with the request that the final draft of the findings be submitted to that group.

She explained that a one-page questionnaire will be mailed within the next few weeks to physicians throughout the State. Miss Miller further explained that the survey is being conducted as a partial fulfillment for a Master of Arts degree from Marshall University.

State Physician Certified

Dr. Dean Roy Goplerud of Morgantown was recently certified by the American Board of Obstetrics and Gynecology. Doctor Goplerud is an Instructor in Obstetrics and Gynecology at the West Virginia University School of Medicine.

Mrs. William H. Evans

Dr. J. T. Spencer Named State Chairman For Deafness Foundation

Dr. James T. Spencer of Charleston has been appointed West Virginia Chairman of the Deafness Research Foundation. The appointment was announced recently by Dr. Gordon D. Hoople, Medical Adviser to the Foundation.

The Deafness Research Foundation is a national and voluntary non-profit organization that promotes scientific research into all types of ear disorders, fosters greater public awareness of the seriousness of deafness, and is currently conducting a nation-wide public education campaign urging people with ear disorders to bequeath their inner ear structures to medical research.

Doctor Spencer, whose specialty is otolaryngology, will act as spokesman for the Foundation at state and regional medical meetings, serve as liaison between the Foundation, the medical profession and the general public, and reply to inquiries about medical aspects of ear disorders addressed to the Foundation by persons residing in West Virginia.

The Deafness Research Foundation launched its campaign for inner ear structures for otologic research in 1960, in cooperation with the American Academy of Ophthalmology and Otolaryngology. Since that time, a network of 27 Temporal Bone Banks, or laboratories, where research is conducted into diseased inner ear structures, has been established throughout the United States.

Motion Picture Schedule

Dr. John J. Mahood of Bluefield, chairman of the motion picture program for the annual meeting at The Greenbrier, has announced that two films will be shown in Governor's Hall each morning prior to the general scientific sessions.

The films on Thursday will be "Reduction Mammoplasty for Pendulous Breasts" and "The Discovery of Insulin." On Friday morning the films will be "Renograms in Renovascular Hypertension" and "Physiology of Normal Menstruation."

The films on Saturday morning will be "Diagnosis and Treatment of Depression in General Practice" and "Mechanism and Control of Nausea and Vomiting."

Second ACP Fall Meeting Planned In Los Angeles, October 8-10

The second annual fall meeting of the American College of Physicians will be held at the Hotel Biltmore in Los Angeles, October 8-10.

The three-day meeting is designed to supplement the College's other national and regional scientific meetings. It will include clinical and basic science presentations, panel discussions on major problems in internal medicine and basic science lectures by noted scientists.

Clinical session topics will include hepatitis, heart disease and defects, liver cirrhosis, jaundice, ulcers, hypertension, kidney disease, arthritis, glandular disease, diabetes and cancer.

Rheumatic Fever Prevention Program

More than 1,800 West Virginians have received free penicillin through the rheumatic fever prevention program of the West Virginia Heart Association and the State Department of Health.

The penicillin is available to medically indigent patients. It is distributed to persons, mostly children, who have had a known attack of rheumatic fever or who have known rheumatic heart disease, cardiac surgery, or congenital heart disease of such magnitude that the referring physician deems prophylaxis advisable.

New ACCP Officers

Dr. Alfred Goldman of St. Louis was elected president of the American College of Chest Physicians during the annual meeting of that organization in San Francisco, June 18-22.

He succeeds Dr. Charles K. Petter of Waukegan, Illinois. Other new officers were elected as follows:

Oliver K. Niess, Major General, USAF, MC, (Ret.), president elect; Dr. Howell S. Randolph, Phoenix, Arizona, first vice president; and Dr. William E. Adams, Chicago, second vice president.

Pulmonary Disease Symposium Planned In Huntington, September 10

The program has been completed for the Cabell County Medical Society's 10th Annual Symposium on "Pulmonary Disease" which will be held at the Frederick Hotel in Huntington on September 10.

Alvan L. Barach, M. D.

Richard H. Overholt, M. D.

Dr. Joseph M. Farrell, the program chairman, said the scientific session would begin promptly at 9 A. M. EDT and be concluded at 5 P. M.

There will be no registration fee and additional information may be obtained by writing to Doctor Farrell, First Huntington National Bank Building, Huntington, W. Va. The Symposium has been submitted for credit by the American Academy of General Practice.

Speakers participating in the program will be as follows:

Maxwell L. Littman, M. D., New York City, Associate Professor of Medicine, New York University School of Medicine and Consultant in Clinical Pathology, Englewood Hospital, Englewood, New Jersey. He received his M. D. degree from the Tulane University School of Medicine and is the author of numerous articles in his specialty.

Richard H. Overholt, M. D., of Boston, Clinical Professor of Surgery, Tufts University School of Medicine and Director, Overholt Thoracic Clinic, Boston. He received his M. D. degree from the University of Nebraska School of Medicine.

Roy R. Greening, M. D., of Philadelphia, Professor of Radiology, Jefferson Medical College and Hospital, Philadelphia. He received his M. D. degree from the Northwestern University Medical School.

Alvan L. Barach, M. D., of New York City, Clinical Professor of Medicine, Columbia University College of Physicians and Surgeons; Consultant in Chest Diseases, Presbyterian Hospital, New York City; President of Research and Education Foundation and Chairman of Council on Research, American College of Chest Physicians. He received his M. D. degree from the Columbia College of Physicians and Surgeons.

Assisting Doctor Farrell as members of the program committee for the Symposium are Drs. Thomas Francis Scott, Albert C. Esposito, Thomas J. Conaty, James P. Carey, Dennis S. O'Connor, G. H. Hunter and M. Lawrence White, Jr.

PEPTIC ULCER • FUNCTIONAL HYPERMOTILITY • IRRITABLE COLON

PYLOROSPASM • BILIARY DYSKINESIA • PANCREATITIS • URETERAL AND URINARY BLADDER SPASM • GASTRITIS

PRO-BANTHINE (propantheline bromide) Assures Authoritative Anticholinergic Control in Gastrointestinal Dysfunctions

The clear and consistent therapeutic benefits of Pro-Banthine (propantheline bromide) have made it the preferred anticholinergic for the past decade.

During that time, many compounds have been developed and proposed as alternatives. In the appraisal of Roach[1] ". . . few, if any, have seemed to offer a distinct improvement, . . ."

Early investigations showed that Pro-Banthine (propantheline bromide) reduces motility and acid secretion and may be used in a wide range of dosage, to bring prompt, positive anticholinergic benefits to patients with peptic ulcer, spastic colon, pylorospasm and related gastrointestinal dysfunctions.

Recent evaluations sustain these earlier judgments. In a current authoritative assessment based mainly on the factors of potency, superiority to atropine, clinical experience and physiologic study, Steinberg and Almy[2] select as the first two preferred anticholinergic drugs, methantheline [Banthine] and propantheline [Pro-Banthine].

The name Pro-Banthine (propantheline bromide) sets a stamp of therapeutic authority on any anticholinergic prescription.

Side Effects and Precautions—Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. The drug is contraindicated in patients with glaucoma or severe cardiac disease.

Dosage—The usual adult dosage is one tablet of 15 mg. with meals and two at bedtime; this amount may be doubled or tripled for patients with severe conditions. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

SEARLE
Chicago, Illinois 60680
Research in the Service of Medicine

1. Roach, T. C.: Therapy of Peptic Ulcer, J. Louisiana Med. Soc. *115*:136-139 (April) 1963.
2. Steinberg, H., and Almy, T. P., Drugs for Gastrointestinal Disturbances, Chapter 21, in Modell, W. (editor): Drugs of Choice—1964-1965, St. Louis, The C. V. Mosby Company, 1964, p. 343.

PYLOROSPASM • BILIARY DYSKINESIA • PANCREATITIS • URETERAL AND URINARY BLADDER SPASM • GASTRITIS

PEPTIC ULCER • FUNCTIONAL HYPERMOTILITY • IRRITABLE COLON

CONVENTION PROGRAM

97th Annual Meeting

of the

West Virginia State Medical Association

THE GREENBRIER, WHITE SULPHUR SPRINGS

August 20-22, 1964

WEDNESDAY AFTERNOON

August 19

(Eastern Daylight Time)

2:30-4:30—Registration, Main Floor Lobby.

1:30—Committee on Medical Education, Hospitals and Scholarships. J. P. McMullen, M. D., *presiding.* (Washington Room, Virginia Wing).

1:30—Insurance Committee. Charles A. Hoffman, M. D., *presiding.* (Jackson Room).

1:30—Constitution and By-Laws Committee. Hu C. Myers, M. D., *presiding.* (Buchanan Room).

3:00—Pre-Convention Meeting of the Council. L. J. Pace, M. D., *presiding.* (Lee Room, Virginia Wing).

WEDNESDAY EVENING

8:30-9:30—Registration.

9:00—First Session of the House of Delegates. Charles L. Goodhand, M. D., *presiding.* (Chesapeake Hall).

Invocation—Tracy N. Spencer, Jr., M. D.

Address: Norman A. Welch, M. D., President, American Medical Association.

Business Meeting.

THURSDAY MORNING

August 20

8:00—Motion Pictures. John J. Mahood, M. D., *in charge.* (Governor's Hall).

8:30-5:00—Registration, Main Floor Lobby.

Opening Exercises

(Governor's Hall)

9:00—Call to Order—William E. Gilmore, M. D., Chairman, Program Committee.

Invocation—Dwight P. Cruikshank, M. D.

Address of Welcome—Charles L. Goodhand, M. D,. President, West Virginia State Medical Association.

Address by Dr. Perry E. Gresham, President of Bethany College. Subject: "The Physician as an Intellectual."

First General Session

Moderator: Richard E. Flood, M. D.

9:45—John M. Howard, M. D., Professor of Surgery, Hahnemann Medical College, Philadelphia, Pennsylvania. Subject: "Clinical Studies of Pancreatitis."

10:30—Eugene F. Poutasse, M. D., Devine-Poutasse Urological Group, Norfolk, Virginia. Subject: "Experiences with Renal Hypertension—Patients of all Ages."

11:15—Recess for Visiting Exhibits.

11:45—Bayard Carter, M. D., Professor and Head of the Department of Obstetrics and Gynecology, Duke University School of Medicine, Durham, North Carolina. Subject: "Endometriosis."

12:30—Recess for Lunch and Visiting Exhibits.

12:30—Luncheon Honoring Past Presidents of the West Virginia State Medical Association. (Tyler Room).

THURSDAY AFTERNOON

2:00—Resolutions Committee. J. C. Huffman, M. D., *presiding.* (Fillmore Room).

2:00—Open Meeting, West Virginia State Society of Allergy. Charles L. Leonard, M. D., *presiding.* (Governor's Hall).

"Symposium on Gastrointestinal and Food Allergy." Merle S. Scherr, M. D., *Moderator.*

Guest Speakers: Maurice Kaufmann, M. D., Clinical Associate Professor of Pediatrics, Uni-

versity of Kentucky College of Medicine, Lexington. Subject: "Food Allergy in Children and Adults."

Frederick A. Stenbuck, M. D., Attending Allergist, Mt. Vernon Hospital, Mt. Vernon, New York. Subject: "Gastrointestinal Allergy."

2:00—Section on Surgery. F. Lloyd Blair, M. D., *presiding*. (Mountaineer Room).

Guest Speaker: John M. Howard, M. D., Philadelphia. Subject: "Pancreatic Cysts and Tumors."

3:30—Cancer Committee. F. Lloyd Blair, M. D., *presiding*. (Lee Room).

3:30—Rehabilitation Committee (Jackson Room).

THURSDAY EVENING

6:00—Cocktail Party, West Virginia Chapter, Medical College of Virginia Alumni Association. A. J. Villani, M. D., *in charge*. (West Virginia Room).

FRIDAY MORNING

August 21

8:15—Motion Pictures. John J. Mahood, M. D., *in charge*. (Governor's Hall).

8:30-5:00—Registration, Main Floor Lobby.

Second General Session

Moderator: Robert D. Crooks, M. D.

9:30—Waldo E. Nelson, M. D., Professor and Head of the Department of Pediatrics, Temple University School of Medicine, Philadelphia, Pennsylvania. Subject: "Fever of Undetermined Origin—Diagnostic Approaches."

10:15—Anthony F. DePalma, M. D., Professor and Head of the Department of Orthopedic Surgery, Jefferson Medical College, Philadelphia, Pennsylvania. Subject: "Slipping of the Upper Femoral Epiphysis (Hip Problem of the Adolescent Patient)."

11:00—Recess for Visiting Exhibits.

11:30—John C. Krantz, Jr., Ph. D., Professor and Head of the Department of Pharmacology, University of Maryland School of Medicine, Baltimore, Maryland. Subject: "The Response of Cells to Drugs."

12:15—Recess for Lunch and Visiting Exhibits.

FRIDAY AFTERNOON

2:00—Section on Internal Medicine. Ralph H. Nestmann, M. D., *presiding*. (Governor's Hall).

Guest Speaker: John C. Krantz, Jr., Ph. D., Baltimore. Subject: "Pharmacologic Approach to Coronary Artery Disease."

Business Meeting.

2:00—West Virginia Pediatric Society. Warren D. Leslie, M. D., *presiding*. (Tyler Room).

Guest Speaker: Waldo E. Nelson, M. D., Philadelphia. Subject. "Potentials for Reducing the Incidence of Premature Births."

2:00—Section on Urology. Donald R. Gilbert, M. D., *presiding*. (Jackson Room).

Guest Speaker: Eugene F. Poutasse, M. D., Norfolk, Virginia. Subject: "Partial Nephrectomy."

2:00—West Virginia Obstetrical and Gynecological Society. Frederick H. Dobbs, M. D., *presiding*. (Mountaineer Room).

Guest Speaker: Bayard Carter, M. D., Durham, North Carolina. Subject: "Chemotherapy in Gynecologic Cancer."

2:00—Section on Orthopedic Surgery. J. Hunter Smith, M. D., *presiding*. (Van Buren Room).

Guest Speaker: Anthony F. DePalma, M. D., Philadelphia. Subject: "Degenerative Changes in the Cervical Spine."

2:00—West Virginia Academy of Ophthalmology and Otolaryngology. James T. Spencer, M. D., *presiding*. (Lee Room, Virginia Wing).

Business Meeting.

2:00—West Virginia Radiological Society. Harold I. Amory, M. D., *presiding*. (Pierce Room).

Guest Speaker: Ted F. Leigh, M. D., Professor of Radiology, Emory University School of Medicine, Atlanta, Georgia. Subject: "Mass Lesions of the Posterior Mediastinum."

3:00—West Virginia Chapter, American Society of Internal Medicine. George F. Evans, M. D., *presiding*. (Governor's Hall).

Business meeting.

5:00—Committee on Nominations. D. E. Greenelch, M. D., *presiding*. (Lee Room, Virginia Wing).

FRIDAY EVENING

10:00—Auxiliary Entertainment — "40th Anniversary Ball." Music by "The Townsmen." (Chesapeake Hall).

SATURDAY MORNING

August 22

8:15—Motion Pictures. John J. Mahood, M. D., *in charge*. (Governor's Hall).

8:30-2:30—Registration, Main Floor Lobby.

Symposium on "Thyroid Disease"

Moderator: Clark K. Sleeth, M. D.

Participants: Members of the Faculty at the West Virginia University School of Medicine.

9:30—George G. Green, M. D., Associate Professor of Radiology. Subject: "Radiological Aspects of the Diagnosis and Treatment of Thyroid Disease."

9:50—John E. Jones, M. D., Assistant Professor of Medicine. Subject "Iodine Metabolism and Familial Goiter."

10:10—Paul C. Desper, M. D., Fellow in Medicine, and Frank E. Medford, M. D., Resident in Medicine. Subject: "Review of West Virginia University Hospital Experience with I^{131} Treatment of Hyperthyroidism."

10:30—Edmund B. Flink, M. D., Professor and Chairman of the Department of Medicine. Subject: "Hashimoto's Disease."

10:50—Recess for Visiting Exhibits.

11:20—Panel Discussion on "Cancer of the Thyroid and Hashimoto's Disease."

Victor M. Napoli, M. D., Assistant Professor of Pathology, will present case material for the panel discussion and participants will include the WVU faculty members and out-of-state guest speakers.

12:15—Recess for Lunch and Visiting Exhibits.

SATURDAY AFTERNOON

1:30—Joint Meeting. West Virginia Society of Anesthesiologists and Section on Neurology, Neurosurgery and Psychiatry. W. H. Rardin, M. D., and Carrel M. Caudill, M. D., *presiding*. (Fillmore Room).

Guest Speaker: John C. Krantz, Jr., Ph. D., Baltimore. Subject: "A Round Trip Journey from Anesthesia to Psychiatry Via the Fluorinated Ethers."

1:30—West Virginia Association of Pathologists. Grover B. Swoyer, M. D., *presiding*. (Jackson Room).

Business Meeting.

3:00—Second and Final Session of the House of Delegates. Charles L. Goodhand, M. D., *presiding*. (Chesapeake Hall).

Invocation—Vernon L. Dyer, M. D.

Presidential Address—Charles L. Goodhand, M. D., President, West Virginia State Medical Association.

Introduction of West Virginia's "General Practitioner of the Year."

Introduction of President of Woman's Auxiliary and Honor Guests.

Introduction of Recipients of 1964 Medical Scholarship Awards.

Business Meeting.

Election of Officers.

Installation of Albert C. Esposito, M. D., of Huntington, as President of the West Virginia State Medical Association.

SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring the Officers of the West Virginia State Medical Association. (Chesapeake Hall Terrace).

CONVENTION SPEAKERS

(Biographical Sketches)

Bayard Carter, M. D., of Durham, North Carolina, Professor of Obstetrics and Gynecology at the Duke University School of Medicine, is a native of Wilmington, Delaware. He received B.A. and M.A. degrees from the Honour School of Physiology, Oxford University, England, 1923-29.

Bayard Carter, M. D.

He served as Head of the Department of Obstetrics and Gynecology at the University of Virginia School of Medicine, 1929-31, at which time he was named Head of the Department of Obstetrics and Gynecology at the Duke University School of Medicine.

He is certified by the American Board of Obstetrics and Gynecology and is a member of the American Association of Obstetricians and Gynecologists, American Gynecological Club and the Society of Pelvic Surgeons.

He is a member of the Southern Medical Association, American Medical Association, Southern Surgical, South Atlantic Association of Obstetricians and Gynecologists, American Gynecological Society and a Fellow of the American College of Obstetricians and Gynecologists.

Heavy Room Reservations At The Greenbrier

Reservations for the 97th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in White Sulphur Springs, August 20-22, are approaching the 500 mark as this issue of *The Journal* goes to press.

The management has again assured Association officials that every effort will be made to arrange accommodations for all those who are interested in attending the convention. It is important, however, that reservations be made as soon as possible so that some idea may be had by the management concerning the total number of rooms that will be needed to house those attending the meeting.

Requests for rooms should be mailed directly to the Reservation Manager, The Greenbrier, White Sulphur Springs, W. Va.

Anthony F. DePalma, M. D., Professor of Orthopedic Surgery at Jefferson Medical College in Philadelphia, is a native of that city and received his M. D. degree in 1929 from Jefferson Medical College. He interned at Philadelphia General Hospital, 1929-31, and served a residency at the New Jersey Orthopaedic Hospital, 1932-39.

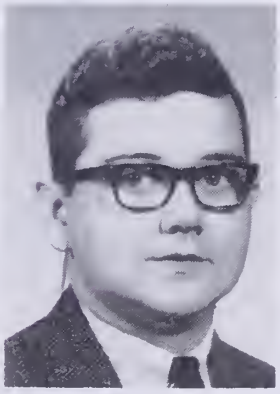
Anthony F. DePalma, M. D.

He served in the Medical Corps of the United States Navy during World War II and was Chief Orthopedic Surgeon at the U. S. Naval Hospital in Philadelphia. He held the rank of Commander at the time of his return to civilian life in 1946.

Doctor DePalma is a Diplomate of the American Board of Orthopaedic Surgery and a member of the American College of Surgeons. He is a Fellow of the American Academy of Orthopedic Surgery and the Association of Bone and Joint Surgeons.

He is the author of four books and numerous papers which have appeared in scientific journals. He is currently serving as Editor-in-Chief of *Clinical Orthopaedics* and as a member of the Editorial Board of *American Practitioner*.

Paul C. Desper, M. D., of Morgantown, Fellow in Medicine, West Virginia University Hospital, is a native of Staunton, Virginia.



Paul C. Desper, M. D.

He attended the secondary schools in Staunton and was graduated from the University of Virginia. He received his M. D. degree in 1961 from the University of Virginia School of Medicine.

He interned at the West Virginia University Hospital, 1961-62, and is currently serving a fellowship in endocrinology and metabolism at the University Hospital.

Doctor Desper will join with five other members of the faculty of the West Virginia University School of Medicine in the presentation of a Symposium on "Thyroid Disease" on Saturday morning, August 22.

Edmund B. Flink, M. D., of Morgantown, Professor and Chairman of the Department of Medicine, West Virginia University School of Medicine, was born in Isanti, Minnesota. He received his M. D. degree from the University of Minnesota Medical School in 1938 and served his internship at the University of Minnesota Hospitals, 1937-39. He also served a residency at that hospital, 1939-42.

Edmund B. Flink, M. D.

He was appointed Instructor in Medicine at the University of Minnesota Medical School in 1942; Assistant Professor, 1943; Associate Professor, 1950 and Professor, 1957. He served as Visiting Professor at Seoul National University in Korea, 1957-58. He was named to his present position at the WVU School of Medicine in May, 1960.

He is a Fellow of the American College of Physicians and is a member of the Monongalia County Medical Society, West Virginia State Medical Association and the American Medical Association. He also is a member of Alpha Omega Alpha, Sigma Xi, the American Society for Clinical Investigation, the Society for Experimental Biology and Medicine, and the American Federation for Clinical Research.

Dr. Perry E. Gresham has served as President of Bethany College since 1953. He received A. B. and B. D. degrees from Texas Christian University and completed requirements for the Ph.D. degree at the University of Chicago and Columbia University. He holds honorary degrees conferred on him by Texas Christian and Culver-Stockton College.

Dr. Perry E. Gresham

He formerly served as Professor of Philosophy at Texas Christian University and is a past president of the Highland Broadcasting Company in Radford, Virginia. He has presented lectures at universities throughout this country, Canada, Mexico and the United Kingdom.

He is chairman of the Commission on Colleges and Universities, North Central Association, and a past president of the International Convention of Christian Churches (Disciples of Christ).

In 1963 he was one of five recipients of plaques from the Freedoms Foundation Leadership for Public Service in Education.

He is the author of four books.

George G. Green, M. D., of Morgantown, Associate Professor of Radiology, West Virginia University School of Medicine, is a native of Bound Brook, New Jersey, and was graduated from Rutgers University. He received his M. D. degree in 1943 from New York Medical College and served his internship at King's County Hospital in Brooklyn, New York.

George G. Green, M. D.

He served as a Captain in the Medical Corps of the United States Army, 1945-47. He served a residency in radiology at Wyoming County Community Hospital in Warsaw, New York, and at several hospitals in New York City. He was certified by the American Board of Radiology in 1950 and he served as councilor to the American College of Radiology from the Radiological Society of New Jersey, 1959-60.

Doctor Green formerly served as director of the Radioisotope Department at Fitkin Memorial Hospital in Neptune, New Jersey, and as consultant in Radiology at Marlboro State Hospital and Allenwood Hospital, both in New Jersey. He was active in the Medical Society of New Jersey before transferring his membership to West Virginia. He served as president of the Radiological Society of New Jersey and was editor of the newsletter published by that organization.

John M. Howard, M. D., of Philadelphia, Professor of Surgery at Hahnemann Medical College, was born in Autaugaville, Alabama. He received his M. D. degree in 1944 from the University of Pennsylvania School of Medicine. He interned and served a residency in surgery at the Hospital of the University of Pennsylvania, 1945-50.

John M. Howard, M. D.

Doctor Howard served as Director of the U.S. Army's Surgical Research Team in Korea, 1951-52, and he is the editor of several books and monograms on battle casualties in Korea. He is maintaining active research and clinical programs in the trauma and surgical fields.

He is certified by the American Board of Surgery and the American Board of Thoracic Surgery, and is a member of the American Medical Association, American College of Surgeons and the National Research Council.

John E. Jones, M. D., of Morgantown, Assistant Professor of Medicine, West Virginia University School of Medicine, is a native of Mt. Pleasant, Utah, and was graduated from the University of Utah.

John E. Jones, M. D.

He received his M. D. degree in 1955 from the University of Utah College of Medicine and served an internship at the University of Minnesota Hospital, 1955-56. He served residencies in internal medicine at the University of Minnesota Hospital, Minneapolis VA Hospital and the West Virginia University Hospital.

He served in the Medical Corps of the United States Navy, 1957-59, and was a Direct U.S.P.H.S. Trainee in Endocrinology, 1959-61.

He was certified by the American Board of Internal Medicine in 1963 and he joined the faculty of the West Virginia University School of Medicine on October 1, 1961.

Maurice Kaufmann, M. D., of Lexington, Kentucky, Clinical Associate Professor of Pediatrics at the University of Kentucky College of Medicine, is a native of Dunlo, Pennsylvania. He received his M. D. degree in 1935 from the University of Louisville School of Medicine.

Maurice Kaufman, M. D.

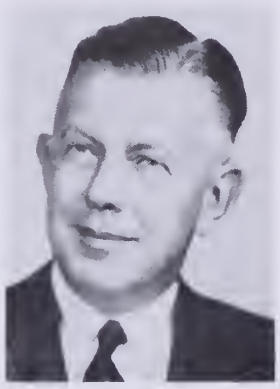
He served an internship at the Louisville General Hospital, 1935-36, and residencies at the Texas Childrens Hospital in Dallas, Texas, and the T. C. Thompson Childrens Hospital in Chattanooga, Tennessee.

Doctor Kaufmann, who was certified in 1948 by the American Board of Pediatrics and in 1953 in Pediatric Allergy, is a Fellow of the American Academy of Allergy, American College of Allergists and the American Academy of Pediatrics.

Annual Meeting on E. D. T.

The Greenbrier, at White Sulphur Springs, operates on Eastern Daylight Time, and EDT will therefore be observed strictly in the schedule of all events in connection with the annual meeting of the West Virginia State Medical Association there, August 20-22, 1964.

John C. Krantz, Jr., of Baltimore, Professor and Head of the Department of Pharmacology at the University of Maryland School of Medicine, was graduated from the University of Maryland and also received his M. S. and Ph. D. degrees from that University. He served as Professor of Pharmacy at the University of Maryland School of Pharmacy and as Professor of Chemistry at the University of Maryland School of Dentistry.



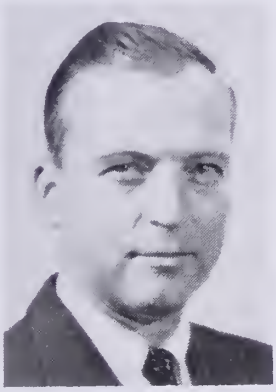
John C. Krantz, Jr., Ph.D.

He served as Director of Pharmacology Research for Sharp and Dohme, 1927-30, and as Chief of the Bureau of Chemistry of the Maryland State Department of Health, 1930-35. He has served as Professor and Head of the Department of Pharmacology at the University of Maryland School of Medicine since 1935.

He is vice president, council member and representative to the National Research Council—American Society of Pharmacology and Experimental Therapeutics. He is secretary of the U. S. Pharmacopeia, and is serving as Chairman of the Advisory Council to the Maryland State Department of Health.

He is the author of three books and more than three hundred scientific papers. He is an associate member of the Medical and Chirurgical Faculty of Maryland and the American Medical Association.

Ted F. Leigh, M. D., of Atlanta, Professor of Radiology, Emory University School of Medicine, received his M. D. degree in 1938 from Emory University School of Medicine. He interned and served residencies in New York City, the latter being at Columbia-Presbyterian Medical Center.

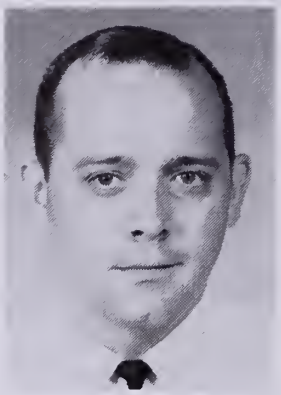


Ted F. Leigh, M. D.

He served in the Medical Corps of the United States Army for five years, serving three and one-half years of this time in the Central Pacific Theater. He was certified in 1947 by the American Board of Radiology and he is a Fellow of the American College of Radiology.

Doctor Leigh has served as Radiologist-in-Chief at the Emory University Hospital since the completion of his residency training in 1948. He is a past chairman of the Section of Radiology of the American Medical Association and of the Southern Medical Association. He is currently serving as chairman of the Commission on Public Relations of the American College of Radiology.

Frank E. Medford, M. D., of Morgantown, Resident in Medicine, West Virginia University Hospital, is a native of Asheville, North Carolina. He was graduated from Wake Forest College and he received his M. D. degree in 1961 from the Bowman Gray School of Medicine.



Frank E. Medford, M. D.

He interned at Memorial Hospital in Charleston, 1961-62, and served a residency in medicine at the same hospital, 1962-63. During the past year, he served six-month residencies in medicine at Charleston Memorial Hospital and West Virginia University Hospital. He was assigned to the metabolic unit at the University Hospital.

Doctor Medford is currently serving a third-year residency in medicine at Charleston Memorial Hospital.

He will join with five members of the WVU School of Medicine faculty in the presentation of a Symposium on "Thyroid Disease" on Saturday morning, August 22.

Victor M. Napoli, M. D., of Morgantown, Assistant Professor of Pathology, West Virginia University School of Medicine, was born in Italy. He received his M. D. degree in 1952 from the University of Naples Medical School and served an internship at Cardarelli General Hospital.

Victor M. Napoli, M. D.

He had postgraduate training in hematology and gastroenterology at the University of Pavia in Italy, and then came to the United States where he interned at Fort Sanders Presbyterian Hospital in Knoxville, Tennessee. He served a residency in pathology at the University of Colorado School of Medicine, 1956-60. He was senior fellow in pathology at the University of Western Ontario, Canada, 1960-61, and he joined the faculty of the WVU School of Medicine in July, 1961.

Doctor Napoli is certified by the American Board of Pathology and is the co-author of three publications in the field of hematology. He is now associated with an Army Research Project concerning pulmonary physiopathology.

Waldo E. Nelson, M. D., of Philadelphia, Professor and Head of the Department of Pediatrics at the Temple University School of Medicine, is a native of McClure, Ohio. He was graduated from Wittenberg College. He received his M. D. degree in 1926 from the University of Cincinnati College of Medicine and interned at Cincinnati General Hospital, 1926-27. He served residencies there and at the Children's Hospital, 1927-29.

Waldo E. Nelson, M. D.

He joined the faculty of the University of Cincinnati College of Medicine in 1929 and was Associate Professor of Pediatrics when he resigned in 1940 to accept appointment as Professor and Chairman of the Department of Pediatrics at Temple University School of Medicine. He also has served as Medical Director of the St. Christopher's Hospital for Children in Philadelphia since 1948.

He has served as Editor of the *Journal of Pediatrics* since 1959 and he is the author of *Textbook of Pediatrics* which is now in its eighth edition.

He was awarded an honorary degree by Wittenberg College in 1956.

Eugene F. Poutasse, M. D., of Norfolk, Virginia, was born in Weston, Masachusetts, and was graduated from Harvard College. He received his M. D. degree in 1943 from Harvard Medical School and is now associated with the Devine-Poutasse Urological group in Norfolk.

Eugene F. Poutasse, M. D.

He interned at Peter-Bent Brigham Hospital and served for three years in the Medical Corps of the United States Navy. He served residencies at Peter-Bent Brigham Hospital and Cleveland Clinic Foundation.

He joined the Staff of Urologic Surgeons at the Cleveland Clinic Foundation in 1950 and served there until he moved to Norfolk early in 1964.

He is certified by the American Board of Urology and is a member of the American College of Surgeons and the American Association of Genito-Urinary Surgeons.

Doctor Poutasse was elected in 1963 to a three-year term on the Board of Governors of the American College of Surgeons as a representative of the American Urological Association.

Frederick A. Stenbuck, Ph. D., M. D., of Mount Vernon, New York, is Attending Allergist at the Mount Vernon Hospital. He was graduated from Cornell University and received graduate degrees at New York and Columbia Universities before receiving his M. D. degree from the Columbia University College of Physicians and Surgeons.

Frederick A. Stenbuck, M. D.

He took postgraduate work in allergy at the New York Post Graduate Medical School under Dr. Will Cook Spain.

Doctor Stenbuck was in charge of the Allergy Clinic at Montefiore Hospital in New York City, from 1937 to 1960.

He is a member of the American Academy of Allergy and a Fellow of both the American College of Allergists and the International Association of Allergology.

Norman A. Welch, M. D., of Boston, President of the American Medical Association, was born in Brockton, Massachusetts. He was graduated in 1926 from Tufts University School of Medicine. He interned and served a residency at the Carney Hospital in Boston, and served as an Instructor in Medicine at Boston University School of Medicine, 1933-43. From 1943-57, he was Clinical Professor of Medicine at Tufts University School of Medicine and Physician-in-Chief at Carney Hospital.

Norman A. Welch, M. D.

He is a past president of the Council of the New England State Medical Societies and was elected a member of the AMA House of Delegates in 1951. He served as Speaker of the House for four years, 1959-63, and was named president elect during the 1963 annual meeting in Atlantic City.

1964 PROGRAM COMMITTEE

William E. Gilmore, M. D.
Chairman

Seigle W. Parks, M. D.
Fairmont

George F. Evans, M. D.
Clarksburg

Clark K. Sleeth, M. D.
Morgantown

Richard E. Flood, M. D.
Weirton

Robert D. Crooks, M. D.
Parkersburg

DELEGATES AND ALTERNATES

B-R-T (3)—Delegates, G. E. Hartle, Philippi; Charles Leonard, Elkins; and A. Kyle Bush, Philippi. Alternates, Cora C. Lenox, Philippi; Homer D. Martin, Dailey; and Raymond W. Cronlund, Philippi.

BOONE (2)—Delegates, W. V. Wilkerson, Whitesville; and Harold H. Howell, Madison. Alternates, James M. Scott, Madison; and William S. Cooley, Wharton.

BROOKE (2)—Delegates, W. T. Booher, Sr., and H. L. Hegner, Wellsburg. Alternates, W. T. Booher, Jr., and J. P. McMullen, Wellsburg.

CABELL (8)—Delegates, John M. Bobbitt, W. D. Bourn, C. Stafford Clay, Gerald J. Eder, I. Ewen Taylor, A. C. Esposito, Harold N. Kagan and Thomas G. Folsom, Huntington. Alternates, Francis L. Coffey, Joseph E. Ricketts, F. C. Hodges, John F. Otto, Jr., Jack Leckie, Clarence H. Boso, Roy A. Edwards, Jr., and James A. Heckman, Huntington.

CENTRAL WEST VIRGINIA (3)—Delegates, R. L. Chamberlain and Ira F. Hartman, Buckhannon; and L. N. Strickland, Summersville. Alternates, J. E. Echols, Richwood; Earl L. Fisher, Gassaway; and J. C. Huffman, Buckhannon.

EASTERN PANHANDLE (3)—Delegates, Leo H. T. Bernstein, Martinsburg; Halvard Wanger, Shepherdstown; and L. Walter Fix, Martinsburg. Alternates, S. Elizabeth McFetridge, Shepherdstown; and Curtis G. Power and E. Andrew Zepp, Martinsburg.

FAYETTE (3)—Delegates, Chuan H. Lee, Montgomery; D. Alene Blake and Joe N. Jarrett, Oak Hill. Alternates, Ivan H. Bush, Jr., Oak Hill; R. DeWitt Peck, Montgomery; and R. S. Birckhead, Gauley Bridge.

GREENBRIER VALLEY (3)—Delegates, Claude L. Houck, Lewisburg; and Stuart T. Bray, White Sulphur Springs.

HANCOCK (3)—Delegates, Richard E. Flood, Myer Bogarad and Ray S. Greco, Weirton.

HARRISON (4)—Delegates, David M. Robinson, Bridgeport; and L. Dale Simmons, Paul E. Gordon and Charles S. Harrison, Clarksburg. Alternates, Richard V. Lynch, Jr., A. J. Weaver, J. D. H. Wilson and B. D. Smith, Clarksburg.

KANAWHA (13)—Delegates, George R. Callender, Jr., Henry R. Glass, Jr., George L. Grubb, and Carl B. Hall, Charleston; Edward Jackson, St. Albans; J. Dennis Kugel, William E. Lawton, Jr., Milton J. Lilly, Kenneth G. MacDonald, Edwin M. Shepherd, Grover B. Swoyer and Pat A. Tuckwiller, Charleston; and Richard C. Wallace, St. Albans. Alternates, Norman Bsharah, Poca; John T. Chambers, W. Edward Duling, A. B. C. Ellison, Donald R. Gilbert, Sherman E. Hatfield and Marion F. Jarrett, Charleston; James S. Kessel, Ripley; and James W. Lane, Page H. Seekford, Charles E. Staats, Robert E. Stone and R. R. Summers, Charleston.

LOGAN (2)—Delegates, Thomas P. Long and Harold Van Hoose, Man. Alternates, Ray M. Kessel, Logan; and Erwin R. Chillag, Holden.

MARION (3)—Delegates, Robert R. Frye, Mannington; and Rupert W. Powell and G. Thomas Evans, Fairmont. Alternates, Jack Calvin Morgan, Joseph T. Mallamo and Louis Edward Baron, Fairmont.

MARSHALL (2)—Delegates, Andrew J. Barger, Glen Dale; and W. P. Bradford, Moundsville. Alternates, H. B. Ashworth, Moundsville; and Thomas O. Dickey, McMechen.

MASON (2)—Delegates, Richard L. Slack and C. Leonard Brown, Pt. Pleasant. Alternate, Dan Glassman, Pt. Pleasant.

McDOWELL (3)—Delegates, Ray E. Burger, R. H. Edwards and A. J. Villani, Welch.

MERCER (4)—Delegates, Charles M. Scott, E. W. McCauley, Wade H. St. Slair, Jr., and J. Brookins Taylor, Bluefield. Alternates, William Prudich, Montcalm; and Charles S. Flynn and Silva Jean B. Neilson, Bluefield.

MINGO (2)—Delegates, John C. Lawson and Robert J. Tchou, Williamson. Alternates, Russell A. Salton and Paul A. Keeney, Williamson.

MONONGALIA (4)—Delegates, William E. King, French R. Miller, Robert J. Fleming and D. Franklin Milam, Morgantown. Alternates, C. A. Logue, Maynard P. Pride, C. Truman Thompson and George A. Curry, Morgantown.

OHIO (6)—Delegates, D. E. Greeneltch, Stephen D. Ward, Joseph L. Curry, Howard G. Weiler and Thomas L. Thomas, Wheeling. Alternates, Robert J. Reed, III, C. B. Buffington, George R. Clarke, Herman Rubin and A. S. Daniel, Wheeling.

PARKERSBURG ACADEMY (5)—Delegates, Charles W. Thacker, Charles H. Barnett, S. William Goff, Robert C. Lincicome and Dwight P. Cruikshank, Parkersburg. Alternates, William E. Gilmore, Parkersburg; Asel P. Hatfield, Harrisville; and George E. McCarty, John H. Gile and John C. Bryce, Parkersburg.

POTOMAC VALLEY (3)—Delegates, Maurice H. Maxwell, Moorefield; Vernon L. Dyer, Petersburg; and William H. Boone, Keyser. Alternates, H. L. Eye, Franklin; Harry F. Coffman, Keyser; and Frederick Moomau, Petersburg.

PRESTON (2)—Delegates, Donald P. Brown and Del Roy R. Davis, Kingwood. Alternates, William H. Harriman, Jr., Terra Alta; and W. Parke Johnson, Jr., Masontown.

RALEIGH (4)—Delegates, Worthy W. McKinney, Grover C. Hedrick, Jr., Warren D. Elliott and Richard G. Starr, Beckley. Alternates, Ross P. Daniel and W. H. Rardin, Beckley.

SUMMERS (2)—Delegates, Buford W. McNeer and A. W. Holmes, Hinton. Alternates, Jack D. Woodrum and D. W. Ritter, Hinton.

TAYLOR (2)—Delegates, Herbert N. Shanes and Charles A. Haislip, Grafton.

WETZEL (2)—Delegates, Lemoyne Coffield and Charles P. Watson, New Martinsville. Alternates, Kent M. Hornbrook and T. B. Gordon, New Martinsville.

WYOMING (2)—Delegates, Frank J. Zsoldos and Ross E. Newman, Mullens.

Reception Committee

James S. Klumpp, *Chairman*

Charles A. Hoffman
Frank J. Holroyd
L. J. Pace
D. E. Greeneltch
Charles L. Goodhand

J. P. McMullen
Clark K. Sleeth
F. Lloyd Blair
William E. Gilmore
Bernard Zimmermann

Hu C. Myers
Donald R. Gilbert
Paul L. McCuskey
D. Franklin Milam
David W. Palmer

Frederick H. Dobbs
Daniel A. Mairs
N. W. Fugo
A. J. Villani
W. D. Leslie
Robert D. Crooks
W. Gene Klingberg

J. C. Pickett
Carl J. Roncaglione
Ralph H. Nestmann
Arnold J. Brody
Seigle W. Parks

George F. Evans
Lyle D. Vincent
Harold I. Amory
Karl J. Myers
Pat A. Tuckwiller

Richard V. Lynch, Jr.
Oliver H. Brundage
Charles E. Andrews
A. B. Curry Ellison
John H. Gile

Grover B. Swoyer
David F. Bell, Jr.
Richard W. Corbitt
Albert C. Esposito
Thomas G. Folsom
J. Hunter Smith
Athey R. Lutz

Official Program
WOMAN'S AUXILIARY
to the

West Virginia State Medical Association
40th Annual Meeting

The Greenbrier
White Sulphur Springs
August 20-22, 1964

WEDNESDAY
August 19

3:00 P. M.—Pre-Convention Board Meeting (Pierce Room). Mrs. Pat A. Tuckwiller, President, *presiding*.

9:00 P. M.—First Session of the House of Delegates, State Medical Association, (Chesapeake Hall).

Address by Norman A. Welch, M. D., President of the American Medical Association. Auxiliary members are invited and urged to attend.

THURSDAY MORNING
August 20

9:00—Formal Opening of the 97th Annual Meeting of the West Virginia State Medical Association.

Address by Dr. Perry E. Gresham, President of Bethany College.

All Auxiliary members are invited to attend. (Governor's Hall).

9:45—Formal Opening of the Convention, Mrs. Pat A. Tuckwiller, President, *presiding*. (Mountaineer Room).

Invocation and Pledge of Loyalty, Mrs. Robert R. Pittman.

Introduction of Honor Guests.

Introduction of Convention Chairmen, Mrs. J. A. B. Holt and Mrs. A. B. Curry Ellison.

Roll Call of Delegates, Mrs. Robert J. Tchou.

Convention Rules of Order, Mrs. John W. Hash, Parliamentarian.

Treasurer's Report, Mrs. Grover C. Hedrick, Jr.

In Memoriam, Mrs. W. V. Wilkerson.

Credentials and Registration, Mrs. James T. Spencer.

Keynote Address—Mrs. William H. Evans, President, Woman's Auxiliary to the American Medical Association.

Recommendations from Pre-Convention Board Meeting, Mrs. Pat A. Tuckwiller.

New Business and Announcements.

Report of Revisions Committee, Mrs. William A. Thornhill, Jr.

Report of Nominating Committee, First Reading, Mrs. Howard G. Weiler, Chairman.

Election of 1965 Nominating Committee.

*Reports of Officers:

President—Mrs. Pat A. Tuckwiller.

President-Elect—Mrs. George A. Curry.

First Vice-President—Mrs. Lysle T. Veach.

Second Vice-President—Mrs. Charles S. Harrison.

Third Vice-President—Mrs. J. N. Jarrett.

Fourth Vice-President—Mrs. Wilson P. Smith.

Treasurer—Mrs. Grover C. Hedrick, Jr.

Recording Secretary—Mrs. Robert J. Tchou.

Corresponding Secretary—Mrs. James T. Spencer.

Parliamentarian—Mrs. John W. Hash.

*Reports of Standing Committees:

AMA-ERF—Mrs. A. J. Villani.

Archives and History—Mrs. J. Dennis Kugel.

By-Laws and Handbook—Mrs. William A. Thornhill, Jr.

Civil Defense and Safety—Mrs. Herbert N. Shanes.

Community Service—Mrs. E. M. Clubb, Jr.

Convention—Mrs. J. A. B. Holt and Mrs. A. B. Curry Ellison.

Editor, State News Bulletin—Mrs. Ralph H. Nestmann.

Circulation Manager—Mrs. N. H. Newhouse.

Finance—Mrs. H. E. Beard.

Health Careers—Mrs. J. C. Huffman.

Members-at-Large—Mrs. Charles L. Leonard.

Mental Health—Mrs. A. C. Chandler.

National Bulletin—Mrs. R. M. Kessel.

Necrology—Mrs. W. V. Wilkerson.

Nutrition—Mrs. Robert Cowen.

Press and Publicity—Mrs. Rupert Powell.

Program—Mrs. William R. Rice.

Resolutions—Mrs. Howard G. Weiler.

Rural Health—Mrs. Lynwood D. Zinn.

Southern Medical Councilor—Mrs. Vernon L. Dyer.

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*These reports are not read but published in the Annual Reports Book.

Presentation of County Presidents:

Boone—Mrs. Harold H. Howell.

Cabell—Mrs. Frank M. Peck.

Central West Virginia—Mrs. Earl L. Fisher.

Eastern Panhandle—Mrs. F. A. Hamilton, Jr.

Fayette—Mrs. William L. Claiborne.

Greenbrier—Mrs. Philip W. Oden.

Hancock—Mrs. Leonard E. Yurko.

Harrison—Mrs. Paul E. Gordon.

Kanawha—Mrs. Joseph A. Smith.

Logan—Mrs. David Mullins.

Marion—Mrs. William A. Ehrgott.

McDowell—Mrs. J. Hunter Smith.

Mercer—Mrs. J. Elliott Blaydes.

Mingo—Mrs. Robert J. Tchou.

Monongalia—Mrs. French R. Miller.

Ohio—Mrs. Herbert G. Dickie, Jr.

Potomac Valley—Mrs. Robert W. Bess, Jr.

Preston—Mrs. William H. Harriman, Jr.

Raleigh—Mrs. John J. Marra.

Taylor—Mrs. Herbert N. Shanes.

Wood—Mrs. Charles W. Thacker.

Wyoming—Mrs. Byron W. Steele.

THURSDAY AFTERNOON

Bridge and Golf
Visit the Exhibits. Center open until 3.30 o'clock.

FRIDAY MORNING

August 21

8:00—Past President's Breakfast, Mrs. Howard G. Weiler, Immediate Past President, *presiding*. (Director's Room).

9:30—Second General Session, Mrs. Pat A. Tuckwiller, President, *presiding*. (Mountaineer Room).

Invocation—Mrs. Ross P. Daniel.

Introduction of Honor Guests.

Roll Call—Mrs. Robert J. Tchou.

Address—Dr. Charles L. Goodhand, President, West Virginia State Medical Association.

Introduction of Mr. Harry Hinton, Field Representative, American Medical Association.

Address—Mr. James Foristel, Legislative Representative, American Medical Association.

Report of Reading Committee—Mrs. Charles S. Harrison.

Report of Woman's Auxiliary to the Student American Medical Association.

Convention Announcements—Mrs. J. A. B. Holt.

Reports of Convention Committees:
Finance—Mrs. Harry E. Beard.

Courtesy Resolutions—Mrs. Herbert G. Dickie, Jr.

Credentials and Registration—Mrs. James T. Spencer.

Press and Publicity—Mrs. Rupert Powell.

Report of the Nominating Committee—Mrs. Howard G. Weiler.

Election of Officers.

Installation of Officers, Mrs. William H. Evans, President of the Woman's Auxiliary to the American Medical Association.

Presentation of President's Pin and Gavel—Mrs. Pat A. Tuckwiller.

Presentation of Past President's Pin— Mrs. Howard G. Weiler.

Inaugural Address—Mrs. George A. Curry.

FRIDAY AFTERNOON

Bridge and Golf

Visit the Exhibits. Center open until 3:30 o'clock.

FRIDAY NIGHT

10:00 P. M. - 1:00 A. M.—40th Anniversary Ball. (Chesapeake Hall).

SATURDAY MORNING

August 22

10:00—Post-Convention Conference and Board Meeting. Mrs. George A. Curry, President, *presiding*. (Mountaineer Room).

SATURDAY AFTERNOON

3:00—Second and Final Session of the House of Delegates. (Chesapeake Hall).

Annual Address by the President, Charles L. Goodhand, M. D., Parkersburg. All Auxiliary members are invited and urged to attend.

SATURDAY EVENING

6:30-7:30—Cocktail Party and Reception Honoring the Officers of the West Virginia State Medical Association. (Chesapeake Hall Terrace).

SCIENTIFIC EXHIBITS

(Exhibit Center)

AMERICAN CANCER SOCIETY W. VA. DIVISION, INC.

"Proctosigmoidoscopy for Asymptomatic Cancer."—A new exhibit prepared by the American Cancer Society. A booklet entitled "Proctosigmoidoscopy for the Detection of Asymptomatic Cancer," will be distributed.

William A. Nichols, Executive Director.

ARTERIOGRAPHY IN THE COMMUNITY HOSPITAL

This exhibit is based on experience in performing over 500 arteriograms during the last 18 months. Emphasis will be placed upon principles which render these procedures relatively safe and efficient at the community hospital level.

Ability to use a variety of technical approaches will be stressed as the most important single ingredient to success and the responsibility of community radiologists to investigate and report their observations will also be illustrated.

Joseph L. Curry, M. D., Andrew K. Butler, M. D., Willard J. Howland, M. D., and Philip P. Wheeler, R. T.

CHILDREN'S BUREAU GUTHRIE PKU EXHIBIT

This exhibit presents a diagrammatic sketch of the Guthrie method of PKU testing of hospital newborns. Diagrams include information relative to: the genetic and biochemical factors in Phenylketonuria; the test method itself, and the "inhibition assay" for blood phenylalanine.

Jane Freeman, M. D.

DISABILITY AND THE MEDICAL REPORT

This display shows information of medical interest. It emphasizes the type of medical information needed by a State team, which includes a physician and a vocational expert, to determine whether your patient meets the social security definition of disability.

DIVISION OF VOCATIONAL REHABILITATION

This table-model exhibit is in two parts. One panel employs color illustrations and brief descriptive material to explain the various steps involved in restoring disabled West Virginians to gainful employment. The other panel—entitled "Five Record-Smashing Years"—presents a statistical summary of the Division's accomplishments between fiscal 1958 and 1962. This panel also utilizes supporting color illustrations. All of the art work for this exhibit was done by a disabled client enrolled in drafting at the West Virginia Rehabilitation Center.

F. Ray Power, Director.

HORMONAL MANAGEMENT OF THE FEMALE REPRODUCTIVE TRACT

This exhibit depicts the medical management with progestational agents of a number of disorders that afflict the female reproductive tract. The disorders covered are: threatened abortion, habitual abortion, infertility, premenstrual tension, dysmenorrhea, secondary amenorrhea and functional bleeding. Also discussed is the approach to the multiple problems presented by the menopause and its most effective treatment with the use of tranquilizers, diuretics and hormonal agents.

F. P. Rhoades, M. D., Detroit, Michigan.

MAMMOGRAPHY

This exhibit includes the introduction; summary of radiological techniques; exhibit of proven cases, benign and malignant diseases of the breast; and summary, including indications and advantages of mammography.

C. H. Joseph Chang, M. D.

MEDICINE AND RELIGION

This exhibit, prepared by the Department of Medicine and Religion of the American Medical Association, points out the purpose and goal of the State and County Medical Societies to bring physicians and clergymen into closer communication; the focus of attention being better total care of patients and parishioners. Additional and more detailed information about this program will be available in the form of booklets and leaflets.

Arne E. Larson, Assistant Director.

THE NATIONAL FOUNDATION MARCH OF DIMES

This exhibit pictorializes Chromosome 21 and its association with Down's Syndrome (Mongolism). It covers standard trisomy, translocation, mosaicism and clinical aspects of Down's Syndrome. A six-page illustrated booklet is available.

Representatives: John C. Stepp and T. Sterling Evans, Sr.

CURRENT CLINICAL RESEARCH AT THE NATIONAL INSTITUTES OF HEALTH

In addition to an explanation of the procedures for physicians to follow in referring patients to the Clinical Center and color transparencies depicting the Center's patient care facilities, this exhibit describes with photographs and text the selected studies currently in progress for which patient referrals will be welcomed.

PROBLEMS AND PRINCIPLES IN HAND SURGERY

The exhibit consists of a number of hand surgery cases, showing the hand before and after treatment, and a brief statement of the principles involved.

Lawrance S. Miller, M. D.

WEST VIRGINIA ASSOCIATION OF MEDICAL ASSISTANTS

Members of the Association will distribute literature concerning the objectives of the organization.

WEST VIRGINIA ASSOCIATION FOR MENTAL HEALTH

W. VA. STATE DEPARTMENT OF HEALTH VACCINATION ASSISTANCE PROJECT

The objective of this exhibit is to demonstrate the vaccination needs of West Virginia. This need is determined by conducting a statistically valid sample survey to determine the needs of West Virginia on a county-by-county basis. Area "samples" are illustrated on maps of each of the counties surveyed. Each map is accompanied by the immunization levels for DPT, smallpox and polio. This information is demonstrated in four different age groups: 0-4, 5-14, 15-39 and 40 and over.

N. H. Dyer, M. D., M. P. H., Director.

WEST VIRGINIA HEART ASSOCIATION

WEST VIRGINIA TUBERCULOSIS AND HEALTH ASSOCIATION

Failure of Tuberculosis Chemotherapy—This exhibit deals with one of the major problems in the control and eradication of pulmonary tuberculosis—the failure of chemotherapy to inactivate the disease. It is of major importance because it leaves the patient chronically ill and a continuing focus of infection, provides a long term economic and public health problem for the community and is a baffling challenge for the physician. The exhibit outlines the definition of chemotherapy failure, the magnitude of the problem (up to 40 per cent in some series of cases), the personal and public health implications, the reasons for failure, the measures needed to prevent and to correct chemotherapy failure. Particular emphasis is placed on the role of the practitioner in prevention and correction.

Thomas A. Deveny, Jr., Executive Director.

THE GREENBRIER

INDUSTRIAL EXHIBITS

(Exhibit Center)

ABBOTT LABORATORIES
North Chicago, Illinois

Booth 7

Abbott Laboratories invites you to visit our exhibit. Our representatives will be happy to answer any questions you may have concerning our leading products and new developments.

AYERST LABORATORIES
New York City

Booth 30

You are cordially invited to visit Ayerst Laboratories Booth 30 which will feature Premarin Intravenous and Spartocin. Premarin Intravenous, conjugated estrogens (equine) for intravenous and intramuscular injection, has been successfully used to control various types of hemorrhagic emergencies due to spontaneous bleeding; preoperatively and during and after surgery; such as EENT bleeding, pulmonary bleeding, gastrointestinal bleeding, genltourinary bleeding, during and after oral surgery and after dental extraction and dysfunctional uterine bleeding. Spartocin, a brand of Sparteine Sulfate, is an oxytocic for induction of labor and treatment of uterine inertia which offers clinically demonstrated effectiveness, safety and ease of administration by intramuscular injection.

THE BAKER LABORATORIES, INC.
Cleveland, Ohio

Booth 2

Baker Laboratories extends a cordial invitation to visit their exhibit for a friendly chat about the nutritional benefits of Baker's Infant Formula, and Varamel —unique flexible formula. Baker products are scientifically formulated to approximate nutritional performance rather than chemical analysis of human milk. Grade-A milk is used, exclusively.

BRISTOL LABORATORIES
Syracuse, New York

Booth 9

Bristol Laboratories' exhibit features Polycillin (ampicillin). This newest member of the Bristol family of synthetic penicillins is the first oral penicillin bactericidal against a significant number of gram-negative and the full spectrum of penicillin G sensitive gram-positive pathogens.

Representatives: Joe Turney, J. R. MacLaughlin, James Mannon and Howard Shirkey.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, New York

Booth 20

Please visit us for information on our products and the newest developments from the extensive research facilities of Burroughs Wellcome & Co. Of particular interest at this meeting are "Neosporin" and "Cortisporin" Creams for topical bacterial infections, "Mantadil" Cream for relief of itching, "Actifed" for respiratory congestion, and "Cardilate" for angina.

Representatives: G. W. Delaney, R. D. Dawson and E. E. Miller.

CIBA PHARMACEUTICAL PRODUCTS, INC.
Summit, New Jersey

Booth 8

THE COCA-COLA COMPANY
Atlanta, Georgia

Booth 43

Ice-cold Coca-Cola served through the courtesy and cooperation of the Coca-Cola Bottling Works, Ronceverte, West Virginia, and The Coca-Cola Company.

ENCYCLOPAEDIA BRITANNICA
Chicago, Illinois

Booth 24

Encyclopaedia Britannica welcomes delegates to the 97th Annual Meeting of the West Virginia State Medical Association and invites them to examine the great new edition of Britannica.

Official delegates may now purchase this magnificant set at an offer only available at our convention exhibits. Visit Britannica's Booth 24 for free descriptive literature.

Representatives: G. Callesis and T. Callesis.

ENDO LABORATORIES, INC.
Garden City, New York

Booth 18

Endo Laboratories will present the latest clinical information relating to our products: Coumadin® (Warfarin Sodium), Numorphan® (Oxymorphone) HCL, Valpin®-PB (Anistotropine Methylbromide with Phenobarital).

Representative: M. J. Berger.

GEIGY PHARMACEUTICALS
Yonkers, New York

Booth 16

Geigy Pharmaceuticals cordially invites members and guests of the Association to visit its exhibit. The exhibit features important new therapeutic developments in the management of cardiovascular diseases as well as current concepts in the control of inflammation; hypertension and edema; depression; obesity; and other disorders, which may be discussed with representatives in attendance.

Representatives: Paul Hatfield, John Bushkar and James Donovan.

HOSPITAL & PHYSICIANS SUPPLY COMPANY
Charleston, West Virginia

Booth 46

You are cordially invited to visit our booth located in space number 46. Our exhibit will consist of the latest in Burdick new Dual-Speed Electrocardiograph, new diagnostic instruments by Welch-Allyn, Castle autoclaves, and all types of emergency resuscitation equipment. We sincerely thank you for your patronage this past year, and shall look forward to visiting with you again.

Representatives: Robert E. Lee Frazier, Robert K. Thacker and Gordon H. Davis.

IBM
Charleston, West Virginia

Booth 19

The IBM Exhibit will feature the various models of electric typewriters and dictation equipment systems which will be of interest to practicing physicians.

Representatives: J. E. Smith and George L. Fullerton.

ELI LILLY AND COMPANY
Indianapolis, Indiana

Booth 44

You are cordially invited to visit the Lilly exhibit. Our sales representatives in attendance welcome your questions about Lilly products and offer you precise information on recent therapeutic developments of Lilly research.

Representatives: H. F. Salsbery, R.Ph., and W. F. Brannon, R.Ph.

MEAD JOHNSON LABORATORIES
Evansville, Indiana

Booth 21

The Mead Johnson Laboratories' exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

MEDICAL ARTS SUPPLY COMPANY
Huntington, West Virginia

Booth 42

You are cordially invited to visit us at our booth. Our representatives will be pleased to have the opportunity to show and discuss with you the latest developments in physio-therapy, diagnostic and examining room equipment, surgical instruments, laboratory supplies and pharmaceuticals.

Representatives: M. L. Clovis and Roy Childers.

MERCK SHARP & DOHME
West Point, Pennsylvania

Booth 13

The theme of the Merck Sharp & Dohme exhibit is "Service to Medicine." One phase features the details of the Merck Sharpe & Dohme Postgraduate Program. Another feature includes information on teaching films for use by the profession and, also, lay films that can be utilized to portray the story of medicine to the lay public. The exhibit is concluded with a display of finger-tip files on selected Merck Sharp & Dohme products.

Representatives: M. S. Robertson and J. E. Payne.

THE NATIONAL DRUG COMPANY
Philadelphia, Pennsylvania

Booth 14

Tepanil, Tepanil Ten-Tab and Orenzyme are being featured at our exhibit.

Tepanil is a completely new compound that curbs the appetite with little or no CNS stimulation.

Orenzyme is the original oral anti-inflammatory enzyme tablet on the market. Orenzyme is indicated for the treatment of any acute inflammatory process when swelling slows recovery.

Representatives: O. C. Glass and C. W. Buchanan.

ORTHO PHARMACEUTICAL CORPORATION
Raritan, New Jersey

Booth 28

Welcome to Booth 28 where Ortho is proud to present the most complete line of medically accepted products for the control of conception. Of special note are the two latest products of the Ortho Research Foundation, Ortho-Novum® Tablets and Delfen® Vaginal Foam. Also on display will be our well-known products for treatment of various forms of vaginitis. Your questions will be welcomed by representatives in attendance.

PFIZER LABORATORIES
New York City

Booth 15

Professional Service Representatives from Pfizer Laboratories will be pleased to have you in attendance at their booth to discuss the latest products of Pfizer research.

WM. P POYTHRESS & COMPANY, INC.
Richmond, Virginia

Booth 3

Mudrane, established Poythress combination for relief of bronchial asthma, and its new companion product, Mudrane GG, will be featured at the Poythress exhibit in Booth 3. Solfoton, Solfoserpine, Trocinate, Panalgesis and Synirin will also be featured. Your requests for descriptive literature, reprints and professional trial quantities of Poythress products are cordially invited.

Representative: Hugh Mackey.

PROFESSIONAL MANAGEMENT AGENCY, INC.
Charleston, West Virginia

Booth 17

ROCHE LABORATORIES
Nutley, New Jersey

Booth 31

New Valium (diazepam) is of use in dealing with psychic tension states stemming from stressful circumstances or whenever somatic complaints are concomitants of emotional factors. It is useful in psychoneurotic conditions manifested by tension, anxiety, fear and fatigue. Valium may also be useful in the alleviation of muscle spasm and spasticity associated with cerebral palsy and athetosis and aid in acute agitation due to alcohol withdrawal.

Representatives: Luther Pratt and John Plymale.

ROSS LABORATORIES
Columbus, Ohio

Booth 11

Ross Laboratories, manufacturer of Similac infant formula products presents the new Ross infant feeding procedure for hospitals—Similac 20. Similac 20 is prediluted, presterilized Similac in disposable glass nursing bottles offering the hospital increased safety, efficiency and economy in formula preparation. The system provides Similac 20, Similac With Iron 20, Similac 13, 5 per cent Glucose Water, Sterilized Water and a choice of disposable or reusable nipples for a complete variety.

Representatives: Ed Rader and Don DeBona.

E. R. SQUIBB & SONS
New York City

Booth 27

E. R. Squibb & Sons has long been a leader in development of new therapeutic agents for prevention and treatment of disease. The results of our diligent research are available to the Medical Profession in new products or improvements in products already marketed. At Booth 27, we will be pleased to present up-to-date information on these advances for your consideration.

Representative: Dan Patton.

SANDOZ PHARMACEUTICALS
Hanover, New Jersey

Booth 12

Sandoz Pharmaceuticals cordially invites you to visit our display at Booth 12, where we are featuring Millaril, Sansert, Cafergot P-B, Fiorinal and Fiorinal with codeine.

Representative: Danny Williams.

W. B. SAUNDERS COMPANY
Philadelphia, Pennsylvania

Booth 45

Saunders will have on display a complete line of medical books, among which will be many new titles of much interest to practicing physicians.

Representative: J. Perry Duncan.

SCHERING CORPORATION
Bloomfield, New Jersey

Booth 22

Schering Corporation invites you to their exhibit where representatives will be on hand to discuss the most recent advances in one of the Schering Product Relief Groups.

Representatives: Jack Rogers and John Carpenter.

STATE MEDICAL ASSOCIATION'S GROUP DISABILITY INSURANCE PROGRAM

Booth 32

The administrator of the Group Disability Insurance Program will provide a brochure describing the plan of the West Virginia State Medical Association's Group Health and Accident and Office Overhead Expense Insurance Programs to visitors at the booth. The fundamental advantage of the group insurance plan is service here in West Virginia. This is an opportunity to meet the administrator—he is the man who will pay your claim.

Representatives: J. Banks Shepherd and A. B. Daniel.

THE STUART COMPANY
Pasadena, California

Booth 26

A cordial invitation is extended to all members and guests attending this meeting to visit the Stuart Company Booth. Specially trained representatives will be in attendance to answer your questions on new products, developed in our modern laboratories, which have particular interest for the medical profession. Products featured are Mylanta, Stuart Prenatal-F, Mulvidren-F and Mulvidren Junior.

Representative: Barry Smith.

THE UPJOHN COMPANY
Kalamazoo, Michigan

Booth 23

U. S. VITAMIN & PHARMACEUTICAL CORP.
New York City

Booth 25

The U. S. Vitamin & Pharmaceutical Corporation cordially invites you to visit their exhibit where Arlidin will be on display, as well as other leading pharmaceutical specialties and nutritional products. Professional service representatives will be in attendance to welcome you and to be of help in answering any inquiries pertaining to the products on display, as well as any of their other products.

Representatives: R. Wallis Everitt and John A. McGraw, Jr.

WALLACE LABORATORIES
Cranbury, New Jersey

Booth 29

We invite you to visit our booth where our representatives in attendance will be pleased to furnish information regarding Wallace products and your related medical questions to assist you in your practice. Featured are our products, 'Miltown', 'Soma', 'Capla' and other drugs of original research.

WARNER-CHILCOTT LABORATORIES
Morris Plains, New Jersey

Booth 47

You are cordially invited to visit the Warner-Chilcott Laboratories exhibit which will feature Gelusil® and Peritrate®.

Representatives: Carmen D. Polino and Earl L. Burg.

Visit the Exhibits!

Plan to spend several hours in the Exhibit Center visiting the Industrial and Scientific Exhibits. They form an integral part of the overall program and this is your opportunity to discuss with trained professional service representatives the new products and therapeutic developments.

Pharmaceutical houses spend millions of dollars annually in medical research. The trained medical representatives who will be in attendance at the meeting are interested in disseminating information about the new drugs and advanced techniques to practicing physicians.

Please take this opportunity to visit every booth and express your appreciation to our exhibitors for their continued cooperation and support.

ANNUAL REPORTS

Cancer Committee

A meeting of the Cancer Committee was held at the Daniel Boone Hotel in Charleston on April 12, 1964. Members of the Committee in attendance were Dr. F. Lloyd Blair of Parkersburg, Chairman; and Drs. W. Hampton St. Clair of Bluefield, Chauncey B. Wright of Huntington, Hu C. Myers of Philippi, and N. W. Fugo of Morgantown.

Other persons attending the meeting included: Dr. Charles L. Goodhand of Parkersburg, President of the State Medical Association; Dr. N. H. Dyer, State Director of Health; Miss Anne Rouse, Cancer Control Division, State Department of Health; Dr. Vernon L. Dyer of Petersburg; Mr. William Nichols, Executive Director of the American Cancer Society, West Virginia Division; and Mr. William H. Lively, Executive Secretary of the State Medical Association. Doctor Blair called upon Miss Rouse to serve as acting secretary during the meeting.

Minutes of the previous meeting were read and it was reported that a new tumor clinic had been organized at King's Daughters' Hospital in Martinsburg. This was of special interest to the Committee because of discussion at a previous meeting concerning the need for a tumor clinic in that area.

Dr. N. H. Dyer discussed the appropriation for the Division of Cancer Control and stated the increase for this year had not been used to expand the program because of an increase in hospital rates. On July 1, 1963, the $20 a day ceiling was lifted and payment is now made for 90 per cent of daily cost. In some instances the amount is almost double and continues to show an increase on revised schedules submitted every three months. The members of the Committee were of the opinion that there should be a level of costs, and a motion that the matter be discussed further at the August meeting was approved. Also, rate sheets are to be made available at that time for a comparison of costs.

Miss Rouse presented a report of the Community Demonstration Project (screening indigent and medically indigent women for cervical cancer in Kanawha and Cabell counties). The project is sponsored by the West Virginia Association of Pathologists, and from approximately 2,700 women examined there have been 49 cases of cancer confirmed. The Committee went on record as approving the project and directed that the following resolution be sent to the Project Chairman, Dr. Peter Ladwig of Charleston:

> "RESOLVED, That the Director of the Cervical Cancer Demonstration Project, sponsored by the West Virginia Association of Pathologists for the screening of indigent and medically indigent women in Kanawha and Cabell counties, be informed that the Cancer Committee of the West Virginia State Medical Association, after reviewing progress of the project, unanimously approves the Project and will seek ways to extend it beyond the demonstration period."

There was considerable discussion concerning the Central Cancer Registry and the Committee approved unanimously a motion that a letter be sent to the President of the American Cancer Society, West Virginia Division, urging that organization to continue support, total or in part, of the Cancer Registry, and that consideration be given to financial help toward annual seminars for hospital personnel responsible for cancer records.

Mr. Nichols discussed the revised service program now in effect through the American Cancer Society, West Virginia Division, and it was suggested that this information be mailed to all physicians practicing in the State.

Respectfully submitted,

F. Lloyd Blair, M. D.,
Chairman

Parkersburg,
June 15, 1964

Committee on Maternal Welfare

The Maternal Welfare Committee of the West Virginia State Medical Association, in conjunction with the Division of Maternal and Child Health of the West Virginia State Health Department, held two meetings at the Daniel Boone Hotel in Charleston on October 6, 1963, and June 7, 1964.

Those attending both meetings were Frederick H. Dobbs, M. D., Chairman and Acting Secretary, and the following members: Clarence H. Boso, M. D., John T. Chambers, M. D., Paul H. Cope, M. D., Nicholas W. Fugo, M. D., George Gevas, M. D., William S. Herold, M. D., and Gilbert A. Ratcliff, M. D.

The Division of Maternal and Child Health of the West Virginia State Health Department was represented by William S. Herold, M. D., Assistant Director; Frederick H. Dobbs, M. D., Obstetric Consultant; and Mrs. Jeanne S. Peccianti, R. N., Obstetric Nurse Consultant.

The Chairman expresses his appreciation for the splendid cooperation of all members of this Committee, for without their valuable assistance in the evaluation of the abstracts and in the direction of the long-range program of this specialty, the overall benefits derived from the work of this Committee would be markedly curtailed. Following the recommendation of the Chairman, the President of the State Medical Association, by retaining the majority of the members of the committee, has facilitated the study of maternal deaths, resulting in a nucleus of interested physicians who attend the meetings and who are professionally qualified to review the case abstracts, to understand the facts contributing

to each maternal death and to make intelligent recommendations for the benefit of the interested physicians and for the edification of the physicians who practice obstetrics in the State.

A ten-year summary of the work of our Committee is in the formulating process with a total of over 260 maternal deaths. While this figure will not compare with the hundreds of maternal deaths in our heavily populated areas, it is significant that our maternal death rate is .5 which is well below the national average.

The splendid cooperation of the interested physicians is appreciated and it is a source of satisfaction that a physician having a maternal death, will forward complete records, autopsies, consultations, laboratory procedures and operative records knowing that the Committee is interested in only one thing; that is, to increase the standards of obstetric practice among the physicians of this State. The data is abstracted as a hypothetical case and the name of the patient, the physician and the hospital are confidential and not available to anyone except the Secretary and his departmental secretary. In some maternal deaths a close chronological description of events, especially blood pressures, pulse and respiration is necessary to understand a sudden demise. We find that the nurses notes, the anesthetist's record, or a resident's description of events sometimes give the clue to the cause of death. The Record Librarians have cooperated splendidly in furnishing complete thermofax copies of the hospital record. These records are treated as confidential material and kept in a locked file.

The Bureau of Vital Statistics, under the direction of Dr. N. H. Dyer and Mr. Paul Shanks, is the primary source of our maternal deaths. The death certificates of all women in the child-bearing age are checked by Miss Georgia Fry and any certificate having any relationship to childbearing is photostated and referred to the Secretary for his scrutiny. If the certificate is classified as a maternal death, the proper letters are written and a questionnaire forwarded to the physician. In borderline cases, a letter is written for clarification.

The Regional Greenbrier Conference on Perinatal Mortality and Morbidity, sponsored by the AMA, was held at The Greenbrier Hotel, October 14-16, 1963. The Maternal Mortality Committee, the Division of Maternal and Child Health, and the West Virginia Obstetrical and Gynecological Society were represented by Drs. Fugo, Klingberg, Goodhand and Herold.

Dr. William S. Herold presented a "Plan For a Birth Defects Register." Each member received an 11-page mimeographed brochure on the proposed plan for studying this problem together with five exhibit forms which will be used in this study. This is a separate and distinct entity from the present program of "Birth Certificate Follow-up of Newborns with Congenital Abnormalities and/or Birth Injuries."

At the inception of the Register, only those births taken from birth and stillborn certificates, showing congenital abnormalities and/or birth injuries, will be entered. This gathering of data will begin with defects and birth injuries occurring after December 31, 1961. Each month the Division of Vital Statistics will send copies of current birth certificates showing newborns with congenital defects and/or birth injuries and copies of all current stillbirth certificates to the Division of Maternal and Child Health. The appropriate and selected entries from them will be entered on the register instruments by a clerk specifically assigned to the Register, and under the direct supervision of the Pediatric Consultant of the Division and/or other physicians employed by the Division.

The Chairman brought to the attention of the Committee the fact that some hospital staffs were failing to complete the medical and health portions of the certificate of Live Births. For example: Under Item 27, "Complications of Pregnancy," the physician failed to enter such items as diabetes, toxemia, and Rh Factor, etc: Under Item 28, "Complications of Labor," the physician failed to include breech presentation, transverse lie, multiple pregnancy, etc.: Under Item 29, "Was There an Operation for Delivery," they failed to record episiotomy as an operation. In one hospital, unless the patient had a cesarean section, Items 27, 28 and 29 were recorded as negative. This eliminated all the complications of the prenatal period and all deliveries were recorded as spontaneous, without episiotomy. This is in a general practice hospital and they perform 40 per cent episiotomies. This lack of information makes the certificate worthless from a statistical standpoint and is not a true picture of obstetric practice.

A Committee on Perinatal Fetal Mortality and Morbidity has been established by the State Medical Association and a meeting was held at the Daniel Boone Hotel in Charleston on March 15, 1964, with representatives of the State Medical Association, the State Health Department, the West Virginia Pediatric Society, the West Virginia Branch of the American Academy of Pediatrics and the Maternal Mortality Committee, at which time the mechanism of establishing such a committee was formulated and committees appointed to carry out this project at state, county, and city levels.

The Chairman presented a plan to consolidate the prenatal and delivery services now active in nine counties. William S. Herold, M. D., Assistant Director of the Division of Maternal and Child Health, has drawn up a plan of referring all complicated obstetrical cases from the clinics, to a central hospital where the services of a specialist in obstetrics is available. One such center is being established at the Medical Center in Morgantown where the complicated cases are referred to Dr. N. W. Fugo for his services. Two other Consultation Centers are being established at Herbert J. Thomas Memorial Hospital to care for the complicated cases referred from the clinics in lower Kanawha, Putnam, Jackson, Lincoln and Mason counties, and Charleston Memorial Hospital will have a Consultation Center for all complicated cases from upper Kanawha, Fayette, Clay, Greenbrier and Boone counties. The fourth Consultation Center will be established at Camden-Clark Hospital in Parkersburg.

After a study of the 21 abstracts of maternal deaths in West Virginia, the Committee discovered that several of these deaths were due to neglect by physician and hospital personnel during the first three or four hours

following delivery. The Committee recommended that all obstetrical units have a recovery area, not especially a recovery room, but an area in the hall, or in the labor room, where personnel would have the patient under *direct observation* for the first two hours following delivery. That the blood pressure, pulse, and vital signs be observed at regular stated intervals, and that this routine check be carried out as a task as equally important as the examination of the patient while in labor. The Chairman has been instructed to prepare a communication to be sent to all hospitals and all physicians who practice obstetrics in the State covering this important period of observation.

TABULATED ANALYSIS OF COMMITTEE'S WORK

The following tables contain the tabulated analysis of the work of the Committee for the current year and these studies are submitted for the information of and study by the members of the West Virginia State Medical Association.

The latest statistical survey for West Virginia between maternal deaths and births is for 1962. In that year there were:

Total Births	37,848
Maternal Deaths	20
Maternal Death Rate	.5

MATERNAL DEATHS, JULY 1, 1963—JUNE 30, 1964

I. Classification of Maternal Deaths Reviewed by Committee During the Period of July 1, 1963—June 30, 1964

Year	*Obstetric*	*Non-Obstetric*
1963-1964	21	

II. Obstetric Death by Cause (1963-1964)

Cause of Death	*No.*	*% of Total*
(1) Postpartum Hemorrhage due to Rupture of Uterus	2	
(2) Hemorrhage due to Uterine Atony	1	
(3) Hemorrhage due to Incomplete Abortion	1	
(4) Hemorrhage due to Retained Placenta	1	
(5) Hemorrhage due to Delivery unattended	1	
(6) Hemorrhage due to Placenta Ablatio	1	
Total Obstetric Death due to Hemorrhage	7	33.3
Pulmonary Embolism	2	9.5
Eclampsia	2	9.5
Infection	2	9.5
Subarachnoid Hemorrhage	2	9.5
Lower Nephron Nephrosis (Ectopic Pregnancy)	1	4.8
Aspiration-Broncho Pneumonia	1	4.8
Air Embolism (Criminal Abortion)	1	4.8
Acute Pulmonary Edema (Mitral Stenosis)	1	4.8
Anesthesia 1	1	4.8
Car Pulmonale (Acute)	1	4.8
Total		100. %

III. Obstetric Deaths by Preventability (1963-1964)

Classification	*No.*	*% of Total*
Preventable by Physician	5	24
Preventable by Patient	2	9.6
Preventable by Patient and Family	3	14.4
Preventable by Patient's Family	1	4.8
Non-Preventable	10	48.
Total	21	100 %

IV. Obstetric Deaths by Place of Delivery (1963-1964)

Place	*No.*	*% of Total*
Home	3	14.3
Hospital	9	43.
4-Bed Clinic	1	4.8
Undelivered	8	38.
Total	21	100. %

V. Obstetric Deaths by Race (1963-1964)

Race	*No.*	*% of Total*
White	17	81.
Negro	3	14.3
Oriental	1	4.8
Total	21	100. %

VI. Obstetric Deaths by Age Groups (1963-1964)

Age Groups	*No.*	*% of Total*
15-19	0	
20-24	7	33.3
25-29	4	19.
30-34	6	29.
35-39	3	14.3
40-44	1	4.8
44 plus	0	
Total	21	100. %

VII. Obstetric Deaths by Parity (1963-64)

Parity	*No.*	*% of Total*
Primipara	5	24.
1-3	11	52.
4-6	0	
7 and over	0	
Unknown	5	24.
Total	21	100. %

VIII. Obstetric Deaths by Weeks of Gestation (1963-1964)

Weeks of Gestation (Lunar Months)	*No.*	*% of Total*
Less than 28 weeks	7	33.3
28-33 weeks	2	9.5
34-39 weeks	4	19.
40 weeks plus	5	24.
Unknown	3	14.3
Total	21	100. %

IX. Obstetric Deaths by Operative Procedure (1963-1964)

Procedure	Preventable	%	Non-Preventable	%	Undetermined
None	6	28.8	5	24.0	
Lower Mid-line Incision			1	4.8	
Cesarean Section, Classical			2	9.6	
Breech Extraction			1	4.8	
Post Mortem Cesarean	1	4.8			
Low Forcepts over a medio lateral episiotomy	2	9.6			
Laparotomy for a ruptured ectopic pregnancy	1	4.8			
Cesarean Section, low cervical	1	4.8	1	4.8	

X. Obstetric Deaths by Type of Consultation (1963-1964)

Type of Consultant	*No.*	*% of Total*
Obstetrician	2	Percentages cannot be calculated because some patients were seen by more than one consultant. But it is significant that 52% had no consultation.
General Practitioner	3	
General Surgeon	2	
Internal Surgeon	1	
Vascular Surgeon	1	
Internist	2	
Anesthetists (M.D.)	2	
Clinical Pathologist	1	
Type Unknown	1	
None	11	

XI. Interval Between Delivery and Death (1963-1964)

Time Interval	*No.*	*% of Total*
Under 1 day	8	38.
1 day - 1 week	1	4.8
1 Week plus	1	4.8
Before Delivery	1	4.8
Unknown (D.O.A.)	1	4.8
Unknown	1	4.8
Undelivered	8	38.
Total	21	100. %

XII. Outcome of Pregnancy in Obstetric Deaths (1963-1964)

Type of Outcome	*No.*	*% of Total*
Livebirth—full term	9	43.
Livebirth—premature	1	4.8
Stillbirth—premature	1	4.8
Spontaneous Abortion	1	4.8
Undelivered	8	38.
Unknown (criminal abortion)	1	4.8
Total	21	100. %

XIII. Analysis of Obstetric Death Certificates (1963-1964)

	No.	*% of Total*
Death Certificate Correct and Complete	15	72
Death Certificate not Correct and Complete	6	28
Total	21	100

XIV. Autopsies Done on Obstetric Deaths (1963-1964)

Autopsy Obtained	8	38.
Autopsy not Obtained	12	57.
Unknown	1	4.8
Total	21	100. %

Definitions

1. *Maternal Death*—The death of any woman dying of any cause whatsoever while pregnant or within six months of the termination of pregnancy, regardless of the duration of the pregnancy at the time of the termination or the method by which it was terminated.

2. *Direct Obstetric Cause of Death*—A death resulting from complications of the pregnancy itself to intervention elected or required by the pregnancy or resulting from the chain of events initiated by the complication or the intervention.

3. *Indirect Obstetric Cause of Death*—A death resulting from disease before or developing during pregnancy (not a direct effect of the pregnancy) which was obviously aggravated by the physiological effects of the pregnancy and caused the death.

4. *Non-Related Cause of Death*—A death occurring during pregnancy or within 90 days of its termination from causes not related to the pregnancy nor to its complication or management.

5. *Factors of Preventability (Avoidability)*—Preventability should be judged in an ideal academic sense. This concept involves three assumptions. First, the physician possessed all the knowledge currently available relating to the factors involved in the death. Second, by experience, he had reached a high level of technical ability. Third, he had available to him all the facilities present in a well-organized and properly equipped hospital. Because of the austerity of these criteria, it is more desirable to determine avoidable factors involved in the death, rather than to label the death as preventable. This allows more specific discussion resulting in better maternal care and reduction of obstetric causes of death.

6. *Factors of Responsibility*—Responsibility should be determined whenever possible and assigned as appropriate to the attending physician, consultant, midwife, hospital, patient, or any combination.

Factors

A. *Professional Factors*—These are concerned with cases where there appear shortcomings in diagnosis, judgment, management, and technique, and include failure to recognize the complication or evaluate it properly. They also include instances of injudicious haste, delay or timing of operative intervention, and failure to utilize currently acceptable methods of treatment. Finally, they would include services which were technically inept, and those failures which could have been averted by proper and timely consultation.

B. *Hospital Factors*—These are concerned with facilities, equipment, or personnel which are inadequate. In terms of modern obstetrics the hazards of delivery cannot be met successfully unless the hospital provides, (1) a separate, well-directed maternity section; (2) a blood bank; (3) competent 24 hour anesthesia service; (4) suitable x-ray facilities; and (5) adequate 24 hour laboratory facilities.

C. *Patient Factors*—These should be recognized, but never as an excuse for professional inadequacy. They are concerned with death resulting from a complication for which there is generally successful treatment but which the patient denied herself by delaying her initial visit to the physician, delaying obtaining medical care after the symptoms were obvious at a layman's level, or finally, by not following the advice and instructions of her physician.

D. *Undetermined Factors*—If because of inadequate evidence a clear-cut decision cannot be made, yet short-comings in care are apparent, it would be preferable to indicate that responsible factors are undetermined. An attempt should be made to determine preventability and to locate the responsible factors.

Analysis of Maternal Deaths

The Committee presents the following conclusions from the analysis of these maternal deaths.

1. *Hemorrhage* again heads the list accounting for eight of the twenty-one obstetric deaths reported. There is an interesting variety of causes and it is in this category that the preventable factors are the most frequent. For example:

   A. *Complete lack of prenatal care and no physician care* was directly or indirectly responsible for four maternal deaths.

      (1) An obese unmarried 400 pound female delivered by herself at home, and hemorrhaged to death from a retained placenta.

(2) Another unmarried female delivered herself at home and was found dead from a postpartum hemorrhage.

(3) The patient lived on an isolated farm where she suffered an incomplete abortion and hemorrhaged all day (17 hours) until her husband returned and took her to a hospital. She was admitted in irreversible shock.

(4) The patient was admitted on her hands and knees on the ambulance carrier, fighting and screaming for her breath. She had a previous cesarean section and was brought in from a farm 20 miles from the hospital. No history of any prenatal care and she expired before any help could be given her with *spontaneous rupture of the uterus.*

B. *Rupture of the uterus* caused an additional death and was due to prolonged use of pressor drugs for induction of labor resulting in a delayed (postpartum) rupture of the uterus.

C. *Ruptured ectopic pregnancy* with a possible blood transfusion reaction resulting in lower nephron nephrosis.

D. *Postpartum hemorrhage* due to uterine atony. Obstetrical pituitrin was used in several doses, and it was following the last dose that the patient went into shock, began an uncontrollable hemorrhage and died.

E. *Hemorrhagic shock* accounted for the last death from hemorrhage. The patient was admitted with severe bleeding in a 7½ months pregnancy from placenta ablatio. Received multiple blood transfusion but patient was in irreversible shock.

F. *Cerebral Vascular Accident* accounted for two maternal deaths.

(1) The patient was seized by a sudden and severe headache and intense pain in the back of the head and neck. She was admitted immediately and a spinal tap revealed a bloody spinal fluid. She expired in 30 minutes after admission.

(2) Patient received a *pitocin drip* for induction of labor which was continued through the delivery and into the postpartum area. Suddenly an hour and fifteen minutes after delivery she had a sudden convulsive seizure and before she could be helped she expired in ten minutes.

G. *Pulmonary embolism* caused three maternal deaths.

(1) The patient had no prenatal care, was delivered by section and signed herself out of the hospital on the fourth postpartum day. On the seventh postpartum day, she phoned her husband saying that she had a sudden severe pain in the chest with difficulty in breathing, then collapsed. She died in the ambulance on the way to the hospital.

(2) Air embolism was discovered at autopsy in a patient who had a self induced criminal abortion.

(3) The patient died of an amniotic fluid embolism 5½ hours following a cesarean section. The etiology was proven by autopsy.

H. *Anesthesia* accounted for two maternal deaths.

(1) Aspiration pneumonia resulted in this death. The patient was operated upon for a ruptured ectopic pregnancy and expired thirty-six hours after surgery with broncho-pneumonia with evidence of aspiration (autopsy).

(2) Immediately after delivery by cesarean section the anesthetist reported no pulse or blood pressure. The patient was maintained by external cardiac message and the cardioscope. The patient went into fibrillation which could not be converted for some time, by that time she had brain damage and was beyond recovery.

I. *Toxemia of Pregnancy* accounted for two maternal deaths.

(1) This patient, with no prenatal care, went into eclampsia with convulsions. The family physician ordered her to the hospital but the admission was delayed by 7 hours, at which time she was convulsing constantly and expired almost immediately after admission.

(2) The patient, with no prenatal care, was brought to a clinic in a state of abortion and with convulsions. Immediately following admission she passed a three months fetus complete with membranes. She had a past history of hypertension and toxemia with her two previous pregnancies. This was classified as an acute exacerbation of a hypertensive vascular disease complicated by pregnancy.

J. *Puerperal Infection* caused two maternal deaths.

(1) Patient had a postpartum puerperal sepsis with septicemia complicated by bilateral adrenal cortical hemorrhage and sickle cell anemia.

(2) The patient was five and a half months in her first pregnancy when she was admitted with acute glomerular nephritis with septicemia. She received heroic therapy but expired of septic shock on the third hospital day.

K. *Pulmonary edema* due to mitral stenosis and heart failure from an old rheumatic heart disease was the cause of the death in this patient. The physician failed to recognize the lesion and did not treat the infection.

Respectfully submitted,

Frederick H. Dobbs, M. D.,
Chairman.

Charleston,
June 16, 1964.

Committee on Medical Economics

The report of the Compensation Sub-Committee was published in the April issue of *The West Virginia Medical Journal.* Comments have been received from individual physicians, from the executive secretary of the West Virginia Association of Manufacturers and from the Employers Service Corporation. These comments were presented to the Council and resolutions made in regards to these comments. They have been incorporated into the recommendations and forwarded to the

Compensation Commissioner along with the schedule of patient benefits for physicians' services recommended by the various sub-sections of the West Virginia State Medical Association. It was requested that the schedule be accepted and utilized prior to August 1, 1964, and that a meeting be held between the Commissioner and representatives of the West Virginia State Medical Association prior to that date.

Of great interest is the following recommendation approved by the Council in regard to the method of payment of the physician for services rendered the Compensation claimant:

"The Council went on record unanimously as recommending that individual physicians have the freedom to decide whether they wish to continue to provide services through a vendor type program or on a private fee for service relationship with the patient. Under the latter system the physician would bill the patient his usual fee and the patient would seek reimbursement from the Compensation Commission."

The activities of the Blue Shield sub-committee has been centered around the presentation of the Blue Plan for medical care for the indigent and medically indigent aged to the Interim Committee of the State Legislature. On May 18 a published booklet of the proposal was submitted to the interim committee by Mr. William R. Huff, executive secretary of the West Virginia Hospital Association. It was recommended that another meeting of the interim committee be held with representatives of the Hospital Association and Medical Association, after further consultation with the Department of Welfare.

The sub-committee on Medicare deals specifically with problems arising under the Dependents Medical Care Program (Dependents of Active Duty Members of the Army, Navy, Air Force, Marine Corps, Coast Guard, Commissioned Members of the U. S. Public Health Service and Commissioned Members of the Coast and Geodetic Survey).

The program is administered by the Medical and Surgical Care Inc., of Parkersburg. The executive director is Mr. Ray A. Wyland. There still is individual dissatisfaction with the fees for service allowed under the contract in West Virginia. Generally, the schedule in all but a few instances is above the present service policies of Blue Shield now in effect in West Virginia covering a higher average income group.

The inequities in individual fees for service by a few is not the greatest complaint received by this committee. The greatest objection to the contract is that if the physician does not feel that he can care for this patient for the maximum fee allowed (and since there is no fee schedule he will not know this except by previous billing or if he has retained the old dependent medical care fee schedule of 1956), the patient must pay him out of his own pocket or seek another physician for medical care. This very obviously interferes with the free choice of physician. It has been suggested that no contract be signed for dependent medical care unless the physicians have the right to render a bill directly to Medical and Surgical Care Incorporated or directly to the patient with the right of the patient to obtain reimbursement from Medical and Surgical Care, Incorporated within the limits of the published patient benefit schedule for physicians' care.

Special Studies

The relative value index will be ready for approval by the sub-sections at the annual meeting.

Joint Conference Committee

The Joint Conference Committee, under the chairmanship of Dr. Harry S. Weeks, Jr., of Wheeling, has continued to meet periodically with the officials of the Department of Welfare. The Commissioner has repeatedly been apprised of the inadequate fee schedule for care of patients under the GMH program. We have felt for many years that the fees were, in most instances, below actual cost to the physicians for this care. We believe this is the basic reason that many feel they can afford to care for only a limited number of GMH patients or none. The question is basically whether you have the right to make your private patients subsidize the care of the welfare patients when your private patients are least able to do so. As a result, a questionnaire was circulated to obtain statistics on overhead expenses in the physicians' offices in West Virginia. The statistics are being compiled at this time and should give us objective material to support our claims before the Commissioner of Welfare, the Legislature and the public. National statistics already have been obtained which fully substantiate this claim.

The universal dislike of the prior authorization form has been discussed with the Commissioner for many years. The elimination of this form is scheduled August 1. At the suggestion of the West Virginia Pharmaceutical Association, a new prescription form was developed and distributed as a method of elimination of prior authorization for prescription drugs. This opened the way to further planning to lead to elimination of prior authorization for physicians and hospital care. In order to do this, identification cards and check stubs will be used to more accurately identify legitimate recipients of medical care under the GMH and MAA programs.

Further discussion of the inequities in the MAA fee schedule have been repeatedly discussed with the Department of Welfare. Adjustments in anesthetic and x-ray fees have been made.

There has been recent dissatisfaction in the method of notification of physicians on regulation changes from the Department of Welfare. The Department has been requested to republish the regulations to date as well as the present fee schedule of both the MAA and GMH. Also, we have asked that in the future all proposed regulations be presented to the Joint Conference Committee and not made effective until approved and adequately circulated to the members of the West Virginia State Medical Association.

Respectfully submitted,

George R. Callender, Jr., M. D.,
Chairman.

Charleston,
June 24, 1964.

Medical Aspects of Sports

The Committee on Medical Aspects of Sports of the State Medical Association gathered data on athletic injuries, especially on football, throughout 1963, to be reported at a meeting in the spring of 1964. This was decided upon at a meeting of the Committee in August, 1963. It was believed the next meeting should not be held during the football season.

It was suggested that an Athletic Injury Conference be held in conjunction with the State Basketball Tournament at West Virginia University in March, 1964. A sub-committee was formed to pursue this, however, due to the illness of one of the committee members the agenda for the conference was not completed in time for it to be held.

A meeting was called on May 16, 1964, after the completion of the State Track Meet. This was held at the Daniel Boone Hotel in Charleston. At this time findings of the year were discussed by the nine members present. Members of the committee are: Dr. Richard W. Corbitt of Parkersburg, Chairman; and Drs. R. L. Chamberlain of Buckhannon; George F. Fordham of Mullens; Robert S. Gatherum of Bluefield; William E. Gilmore of Parkersburg; Henry R. Glass, Jr. of Charleston; J. W. Hesen, Jr., of Morgantown; Gregory B. Krivchenia of Wheeling; George Naymick of Weirton; W. H. Rardin of Beckley; George W. Rose of Clarksburg; and Harlan A. Stiles of Huntington.

A communication was received from Mr. W. Gordon Eismon, Executive Secretary of the West Virginia Secondary Schools Activities Commission, stating that there was much better coverage of athletic contests this past year by physicians (as per the committee's request to the different county societies.)

Physicial conditioning of the athlete was discussed. A motion was made and passed on to the Commission that West Virginia high schools be allowed to have a conditioning program for two weeks prior to the regular season practice session and equipment be limited to football shoes and a football. This could be held at either a camp or elsewhere. It is again stressed that the committee members feel that conditioning is the most important thing in the prevention of athletic injuries. It was felt that the pre-season practice sessions are entirely too short.

It recommended to the Secondary Schools Activities Commission that a form letter be sent to all coaches to contact their local medical societies if home games are not covered by a physician and to work this out with the coaches if at all possible.

The Committee has again been asked to put on a program in conjunction with the meeting of the West Virginia High School Coaches Association in Parkersburg on Friday evening, August 7, 1964. This will be done. This committee hopes to have Dr. Kenneth S. Clarke of the Committee on Health and Health Education of the American Medical Association as a speaker for this meeting to be followed by a panel discussion in which he also will be a member.

The Committee discussed the desirability of putting on an Athletic Injury Conference with physicians and coaches in conjunction with the State High School Basketball tournament which will be held in Charleston in March, 1965.

Respectfully submitted,

Richard W. Corbitt, M. D.,
Chairman.

Parkersburg,
June 22, 1964.

Medico-Pharmaceutical Relations

The first National Congress on Medicine and Pharmacy was held in Chicago, March 12-13 with 340 people registered. The Congress was sponsored by the Commission on Medicine and Pharmacy made up of representatives from the American Medical Association, American Pharmaceutical Association and the National Association of Retail Druggists.

West Virginia delegates to the Congress were Dr. L. Dale Simmons of Clarksburg, Chairman of the Committee on Medico - Pharmaceutical Relations; Dr. Charles L. Goodhand of Parkersburg, President of the West Virginia State Medical Association; Mr. Joseph Pugh of Martinsburg, President of the West Virginia State Pharmaceutical Association; and Mr. William J. Dixon of Oak Hill, Secretary-Manager of the State Pharmaceutical Association.

Dr. George M. Fister of Ogden, Utah, chairman of the Commission and immediate past president of the American Medical Association, opened the meeting. He stressed that "Our goal must be active, effective liaision programs in every state and in every sizeable county or metropolitan area. The Joint Commission on Medicine and Pharmacy can provide leadership and guidance on the national level, but maximum results can be achieved only through state and local cooperation."

Various topics concerning ethics, inter-professional relations, economics, problems facing medicine and pharmacy, and ethics in law were discussed with lively question and answer periods after each discussion.

On one panel discussion made up of three lawyers representing each of the three divisions of the Commission these principles were brought out:

1. Believe in a safeguard for medicine and pharmacy.
2. Improve professional skill and knowledge.
3. Share professional skill and knowledge with colleagues.
4. Oppose quackery and cultism.
5. Maintain honor and dignity.
6. Affiliate with professional organizations.
7. The principles of ethics applicable to all. It is our duty to expose unethical conduct.
8. The prime essence: "the interest of the patient is paramount" in contrast to a business where the slogan is "let the buyer beware."
9. Freedom of both physician and pharmacist should be preserved.
10. Confidential communications should be honored.

11. There should be no conflict in interest between patient and physician, or pharmacist.
12. There should be non-interference with doctor-pharmacist relationship. Do not substitute in prescriptions and do not undermine confidence of physician.
13. Fees should be fair and just.
14. All the above are for the betterment of public health.

Reason, clarity and common sense can solve all problems related to medicine and pharmacy. Interprofessionalism must be improved by the interchange of ideas.

As a direct result of this meeting and of the West Virginia delegation of physicians and pharmacists present, it was decided to work toward a better professional understanding and collaboration of all pharmacists and physicians in West Virginia.

An Inter-professional Code of Understanding was worked out and will be presented to the West Virginia State Pharmaceutical Association at its annual meeting in July, 1964, for approval. It will then be presented to the West Virginia State Medical Association for its approval.

Recommendations include changing the name of the committee from "Medico-Pharmaceutical Relations" to the "Committee on Medicine and Pharmacy," and to make this a standing committee of the State Medical Association.

To maintain liaison between the West Virginia State Medical Association and the West Virginia Pharmaceutical Association at the local level it was recommended that each medical society president appoint a "Committee on Medicine and Pharmacy." This committee will work with a pharmacist coordinator in each area already appointed by Joseph Pugh, President of the West Virginia State Pharmaceutical Association.

Respectfully submitted,

L. Dale Simmons, M. D.,
Chairman.

Clarksburg,
June 23, 1964.

Mental Health

Among the activities of the Mental Health Committee during 1963-64 was its participation in the various aspects of the program of mental health planning inaugurated jointly by the State Department of Mental Health and the West Virginia State Medical Association.

The enabling legislation passed by Congress providing for the establishment of mental health centers prompted the appointment by the State Mental Health Department of a number of committees to survey the State for the purpose of determining the needs in various areas of mental health activity.

Members of the Committee on Mental Health have key roles in all of these committees and the Chairman of the Committee has been appointed to the Governor's Advisory Committee on Mental Health.

Beyond this, the Chairman of the Committee represented the State Medical Association at the 10th Annual Conference on Mental Health which was held in Chicago in February, 1964. He was able to learn what the most important areas of mental health needs are in the country. It also was determined at this meeting that all states face problems in the areas of (1) obtaining cooperation from the medical community in solving the problems of mental health; (2) the establishment of emergency psychiatric services; and (3) the role of general practitioners as treatment personnel for the large number of mental health patients.

State medical associations were asked to provide the emergency services in communities where this is possible. These groups also were asked to appoint committees on mental health at the county level so that mental health activities will have a "grass roots" representation.

Physicians, both psychiatrists and non-psychiatrists, were urged to provide leadership among citizens' groups and to give direction to this enormous effort being made to establish mental health centers in the various communities.

The Committee looked into the manner in which the law was being implemented in West Virginia and, with few exceptions, found that the planning met with our approval.

It is highly essential, I think, that some continuity be afforded to this Committee in the light of the Second Annual AMA Conference on Mental Health which will be held in October, 1964. At all meetings that the Chairman has attended emphasis has been placed on this aspect of mental health planning; namely, that a continuity of personnel in the committees be maintained.

All in all this has been a good year with definite progress being made in cooperation with the official government agencies toward the goal of establishing mental health centers in West Virginia.

Respectfully submitted,

William B. Rossman, M. D.,
Chairman.

Charleston,
June 2, 1964.

Medicine and Religion

The Committee on Medicine and Religion of the West Virginia State Medical Association, authorized in an amendment to the Association's By-Laws by the House of Delegates in August, 1963, held its organizational meeting at the Daniel Boone Hotel in Charleston on November 19, 1963.

Those attending this meeting were Dr. Tracy N. Spencer, Jr., of South Charleston, the Chairman; and Drs. Vernon L. Dyer of Petersburg; Frederick H. Dobbs of Charleston; and John C. Bryce of Parkersburg; Mr. Arne E. Larson of Chicago, Assistant Director of the AMA Department of Medicine and Religion; Mr. Jerry Gould of Charleston, Executive Assistant of the State Medical Association; and Dr. John S. Blagg of South Charleston, who attended as a guest.

Mr. Larson gave the objectives of the overall program in an introduction to the 28 minute color film, "The One Who Heals."

The Committee discussed various facets of the program and authorized the Chairman to write to the President of each Component Society asking that a Committee on Medicine and Religion be appointed within the Society.

The second meeting of the Committee was held at the Daniel Boone Hotel in Charleston, April 12, 1964.

Those attending were Dr. Tracy N. Spencer, Jr., the Chairman; and Drs. Frederick H. Dobbs of Charleston and Vernon L. Dyer of Petersburg; Mr. Arne E. Larson of Chicago; and Mr. William H. Lively, of Charleston, Executive Secretary, and Mr. Jerry Gould, Executive Assistant of the State Medical Association.

Dr. Charles L. Goodhand of Parkersburg, President of the State Medical Association, and Dr. Marshall J. Carper of Charleston, Chairman of the Kanawha Medical Society Committee on Medicine and Religion, were guests.

Doctor Spencer discussed briefly a chaplaincy workshop which had been held at Herbert J. Thomas Memorial Hospital in South Charleston and the Seminar on Medicine and Religion which had been held the previous day at the Holiday Inn in Charleston. The Seminar was attended by more than 40 physicians and ministers. The Committee extended an invitation to the AMA's Department of Medicine and Religion to make available one of its exhibits for the 97th Annual Meeting of the West Virginia State Medical Association at The Greenbrier in August.

The following component societies now have committees on medicine and religion:

Barbour-Randolph-Tucker, Cabell, Eastern Panhandle, Fayette, Kanawha, Marshall, Monongalia, Ohio, and the Parkersburg Academy of Medicine.

Respectfully submitted,

Tracy N. Spencer, Jr., M. D.,
Chairman.

South Charleston,
June 24, 1964.

Rural Health Committee

The American Medical Association's 17th Annual National Conference on Rural Health was held in Columbus, Ohio, March 6-7.

Your Chairman attended the meeting and presented a report on the recent accomplishments of the Rural Health Committee of the West Virginia State Medical Association. Several other members of the Association and the Woman's Auxiliary also attended the Conference.

Dr. Paul A. Miller, President of West Virginia University, delivered the keynote address and his remarks were well received.

Plans have nearly been completed for the State Rural Health Conference which will be held at Jackson's Mill on October 1. An interesting program has been arranged and we are looking forward to a most successful meeting.

Respectfully submitted,

Earl L. Fisher, M. D.,
Chairman.

Gassaway,
June 15, 1964.

Tuberculosis Committee

The Tuberculosis Committee of the West Virginia State Medical Association met in Charleston on May 15, 1964.

Present were: William L. Cooke, M. D., Chairman; Charles E. Andrews, M. D.; N. Allen Dyer, M. D.; George F. Evans, M. D.; Ralph H. Nestmann, M. D.; Seigle W. Parks, M. D., vice president of the State Medical Association; and Mr. Thomas A. Deveny, Jr., Executive Director of West Virginia Tuberculosis and Health Association.

The present status of tuberculosis in West Virginia was reviewed with some alarm. While the death rate per 100,000 population for the United States was reported by the USPHS as 5.1 for 1962, the West Virginia rate was 8.1. Five years ago, in 1957, the National death rate was 7.8; while West Virginia had a rate of 8.5 deaths. At that time only one neighboring state had a rate lower than West Virginia. Five years later there is only one of our neighbors with a higher death rate. In 1960 the death rate reached a low of 5.6 deaths per 100,000 but has increased in each succeeding year. The case rate per 100,000 remains between 33 and 39.

There has been a loss of some $35,000 from federal funds for the next fiscal year in U. S. Public Health Service formula grants to states. Dr. N. Allen Dyer reported that the West Virginia Department of Health has been able to obtain some $17,000 in project grants to counterbalance the first amount.

Tuberculosis clinics in the counties of West Virginia were discussed and about 50 per cent of the counties do not have clinics. Dr. Charles E. Andrews reported that the West Virginia University School of Medicine would be interested in assisting in staffing such clinics and in training local physicians to conduct the clinics. Dr. George F. Evans expressed the opinion that the members of The West Virginia State Medical Association would staff clinics if the proper appeal were made. The Chairman stated that some equitable travel allowance to provide for time lost as well as mileage would be desirable.

The Tuberculosis Committee is on record as requesting close cooperation between the State Department of Health, the WVU School of Medicine, and the members of the West Virginia State Medical Association in an effort to reverse the increasing death rate from tuberculosis in West Virginia.

Respectfully submitted,

William L. Cooke, M. D.,
Chairman.

Charleston,
June 18, 1964.

WVU Medical Center
—News—

• Compiled from material furnished by Howard Lewis, Director, Medical Center News and Information Services, Morgantown, West Virginia.

THREE graduates of the West Virginia University School of Medicine were among the 14 new physicians who began their one-year internship at the University Hospital on July 1.

Drs. W. Scott Bowie of Morgantown, Susan Shaw Gustke of New Cumberland and William A. Morrison of Terra Alta were among the 40 students who received their M. D. degrees at commencement exercises in Morgantown on June 1.

Other new interns are as follows:

Dr. Edwin J. Morgan of Pittsburgh, University of Pittsburgh School of Medicine.

Dr. Anton Vos of Vlaardingen, Holland, University of Utrecht, The Netherlands.

Dr. David J. Carlson of Hopkins, Minnesota, University of Minnesota Medical School.

Dr. James R. Gaskell of Ellwood City, Pennsylvania, University of Pittsburgh School of Medicine.

Dr. Gary F. Gilbertson of Minnespolia, Minnesota, University of Minnesota Medical School.

Dr. Paul J. Jakubec of Weston, University of Pittsburgh School of Medicine.

Dr. Nam Ha Paik of Seoul, Korea, Seoul National University.

Dr. Phillip J. Ranheim of Moorehead, Minnesota, University of Minnesota Medical School.

Dr. John A. Reichert of Minneapolis, University of Minnesota Medical School.

Dr. Gerald F. Ronning of St. Paul, Minnesota, University of Minnesota Medical School.

Dr. Thomas J. Rose of Minneapolis, University of Minnesota Medical School.

VA Physician Added to Faculty

Dr. Charles A. Jones of Clarksburg has accepted an appointment as Clinical Professor of Medicine at the WVU School of Medicine.

Doctor Jones is Chief of Medicine at the Clarksburg VA Hospital and formerly served in that same capacity at the Miners Memorial Hospital in South Williamson, Kentucky.

He is a native of Kosciusko, Mississippi, and attended the University of Mississippi. He received his M. D. degree in 1934 from the Tulane University School of Medicine.

Postgraduate Course on TB

A two-day postgraduate course on "Tuberculosis," sponsored by the WVU School of Medicine and the West Virginia Tuberculosis and Health Association, will be held in Morgantown and Clarksburg October 6-7.

Dr. Charles E. Andrews, Professor of Medicine at the WVU School of Medicine, will preside at the first scientific session at the WVU Medical Center in Morgantown on Tuesday, October 6.

Doctor Andrews said that three prominent physicians have accepted invitations to present papers and a fourth will be added.

The guest speakers will include Dr. James W. Raleigh of New York City, Medical Director of the American Thoracic Society; Dr. John S. Chapman of Dallas, Texas, Assistant Dean of the University of Texas Southwestern Medical School; and Dr. William B. Tucker of Washington, D. C., Director of Medical Service of the Veterans Administration Department of Medicine and Surgery.

Two Physicians Join Faculty

Drs. Roland E. Schmidt and Lester Kiefer, natives of Bemidji, Minnesota, and Baltimore, have joined the School of Medicine Faculty.

Doctor Schmidt, who was named Assistant Professor of Pediatrics, graduated from the University of Washington and received his M. D. degree from the University of Chicago School of Medicine.

He was in private practice for several years before serving a residency in pediatrics at the University of North Carolina. He served as an Instructor in Pediatrics at the University of North Carolina School of Medicine before assuming his duties at WVU on July 1.

Doctor Kiefer will serve as Clinical Assistant Professor of Pathology. He was graduated from the University of Maryland and received his M. D. degree from the University of Pennsylvania School of Medicine. He is now pathologist and director of the laboratory at Memorial Hospital in Cumberland, Maryland, and has been teaching pathology at the University of Maryland School of Medicine since 1957.

Receives Grant for Glaucoma Program

Dr. Robert R. Trotter, Associate Professor of Surgery and Chairman, Division of Ophthalmology, recently was awarded a $21,757 grant by the Department of Health, Education and Welfare. The grant is for the continuation of a glaucoma detection program at the University Medical Center.

Doctor Trotter is a native of Morgantown and was graduated from West Virginia University. He attended the two-year School of Medicine at WVU and received the M. D. degree from the Temple University School of Medicine.

The West Virginia Medical Journal

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An Evaluation of the Glucose Oxidase Skin Test In the Diagnosis of Diabetes Mellitus

Frank E. Medford, M. D.

A rapid, sensitive and specific test for diabetes mellitus would be of much benefit to the physician in his office and in mass diabetes mellitus detection drives. Recent work by Miller and Ridolfo[2] indicates that the skin surface-glucose test may be of some value in the detection of this disease. They found that of 86 diabetics, 60 gave positive skin tests, with 8 of the 60 having negative urine and normal blood sugar values. Of 64 controls, 11 had positive tests; of this number 7 were diabetic by the standard oral glucose tolerance test, and 2 had abnormal cortisone glucose tolerance tests.

Studies by Cornbleet[1] reveal that many factors affect the glucose content of the skin. Epinephrine, histamine, heat, ultraviolet light, chrysarobin (a reducing agent), any hyperemia following x-ray exposure and vasoconstriction from cold will increase the skin glucose content. Insulin, cold and serious liver disease will decrease the glucose content of the skin. Factors which Cornbleet did not consider are skin thickness, callus formation and activity of sweat glands. With so many elements involved in relation to the skin glucose content, one wonders if the skin test is as valid as the evidence seems to indicate. It was for this reason that the present study was undertaken.

Material and Methods

Test subjects consisted of 50 known diabetics who were on therapy and 50 controls who had no history of diabetes mellitus and apparently were free from the disease. The patients with diabetes mellitus were chosen in no particular manner and consisted both of inpatients and outpatients. The control subjects likewise were chosen in no particular manner and consisted of medical students, nurses, and patients who were in the hospital for reasons other than diabetes mellitus, other endocrine diseases and acute conditions.

The Author.

- **Frank E. Medford, M. D., Resident in Medicine, Memorial Hospital, Charleston, W. Va.**

The skin test was carried out after the method of Miller and Ridolfo.[2] All subjects were questioned about diet, and none of the latter was found to be grossly deficient in carbohydrate content. There was no attempt to standardize the postprandial test time, but the period of time between the last meal and test time was recorded. The hands were washed with warm water without the use of soap or detergents. From one-half to one hour afterwards, two strips of Clinistix* were moistened by immersion in distilled water until bubbles ceased to rise from the strips. The test subject then held the strips between the thumb and index finger tips, one in each hand, for 1 minute, and the strips then were removed. Any blue coloration of the strip was considered positive evidence of the presence of glucose, and the results were recorded for the appropriate hand as either positive or negative. In the final analysis, however, if either strip was positive the test was considered positive.

Urine, collected from each subject immediately after skin testing, was tested with Clinistix, and the result recorded as positive or negative. Blood, either capillary or venous, was collected

*Product of Ames Company, Inc.

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Table 1

Folin-Wu Method

	Capillary Blood	*Venous Blood*
0 hr.	160 mg.% (140 mg.% probable)	140 mg.% (120 mg.% probable)
½ hr.	200 mg.%	180 mg.%
1 hr.	200 mg.%	180 mg.%
1½ hrs.	180 mg.%	160 mg.%
2 hrs.	160 mg.% (140 mg.% probable)	140 mg.% (120 mg.% probable)
2½ hrs.	160 mg.% "	140 mg.% "
3 hrs.	160 mg.% "	140 mg.% "
4 hrs.	160 mg.% "	140 mg.% "

Somoygi-Nelson Method

	Capillary Blood	*Venous Blood*
0 hr.	140 mg.% (120 mg.% probable)	120 mg.% (110 mg.% probable)
½ hr.	180 mg.%	160 mg.%
1 hr.	180 mg.%	160 mg.%
1½ hrs.	160 mg.%	140 mg.%
2 hrs.	140 mg.% (120 mg.% probable)	120 mg.% (110 mg.% probable)
2½ hrs.	140 mg.% "	120 mg.% "
3 hrs.	140 mg.% "	120 mg.% "
4 hrs.	140 mg.% "	120 mg.% "

within minutes of the skin test, and the sugar content determined after the method either of Somogyi-Nelson or Folin-Wu. The results were recorded without correction for the method of collection or method of determination of blood sugar. Depending on postprandial time, method of blood collection and method of blood sugar determination, the values for blood sugar content were extrapolated, using standard glucose tolerance curve values (Table 1) and reported as abnormal (or positive) if they exceeded the specified value at the particular time. Those cases with positive skin tests and normoglycemia were subjected to the standard oral glucose tolerance test. The usual diet was maintained until 12 hours prior to the test at which time fasting began. After the fasting blood sugar was drawn, the subject received orally a mixture of glucose 100 Gm., water 500 ml. and a small amount of lemon juice. Blood sugar was drawn at ½ hour, 1, 2 and 3 hours, if possible. The values were compared with those given in Table 1, depending on method of collection of blood and method of glucose determination. When values exceeded those for the methods used, both in elevation of blood sugar level and the 2-hour value, the curve was considered diabetic. Any other abnormal combination was considered indicative of a probable diabetic curve, i.e., if the 2-hour value is too high but the total elevation is within normal range or if the total elevation is excessive and the 2-hour value is slightly above normal values.

Results

Results of the tests in the group with diabetes mellitus are summarized in Table 2. There were 35 females and 15 males. Age range was from 13 to 84 years, with a mean of 52.7 years.

The skin test was positive, with normoglycemia and negative urine, in 3 cases. In 13 cases the skin test was negative while the urine was positive and hyperglycemia existed. In 4 cases the skin test and urine were negative while normoglycemia existed. In 43 cases the disease could have been detected by urine sugar and blood sugar determinations. The combination of negative skin test, positive urine test and normoglycemia did not occur in this group.

Results of the tests in the control group are summarized in Table 3. There was an equal number of males and females, with age range from 23 to 83 years and a mean of 48.6 years. The combination of negative skin test, negative urine and normoglycemia appeared in 36 of the 50 cases. There were 11 instances of positive skin test, negative urine and normoglycemia. The peculiar combination of negative skin test, positive urine and normoglycemia appeared in one case.

Only 4 of the 11 persons with a positive skin test, negative urine and normoglycemia were available for the glucose tolerance test; results appear in Table 4. It will be noted that two have normal curves, one (Pri.) is borderline, and one is frankly abnormal. Control subject 43 (Jes.) was found to have blood sugar values of 94, 121, 155, 135 and 119 mg. per cent at 0, ½, 1, 2 and 3 hours, respectively, using venous blood and the Somogyi-Nelson method of blood sugar determination. It may be seen that in this case the skin test and urine were negative and fasting normoglycemia existed. This case would have been missed by the skin test, urine analysis for sugar and fasting blood sugar.

Discussion

Trimble and Carey[3] studied the sugar content of human skin by hydrolyzing it with boiling water and determining the sugar content by the Folin-Wu method. They called it the true sugar content; it seems, however, that boiling would release much of the bound sugar. The Folin-Wu method certainly measured more than true sugar. They found that skin from normal individuals contained 56.8 mg. per cent sugar and skin from diabetics contained about 144 mg. per cent. The amount of nonfermentable reducing substances in nondiabetic skin was found to be 12 mg. per cent and that in diabetic skin 19 mg. per cent.

Cornbleet,[1] using a different method for sugar determination, found that normal human skin contained from 60.2 to 84.7 mg. percent dextrose and from 68.1 to 84.7 mg. per cent glycogen. He maintained that the blood sugar was always higher than the skin sugar and that the skin sugar paralleled that of the blood with a lag in its rise and fall. After an oral carbohydrate load, the blood sugar reaches its height in ½ hour and falls to normal in 2 hours. The skin sugar under the same conditions will reach its height at 1 hour and fall to normal in 3 hours.

Use of the glucose oxidase skin test thus has some basis. Results of this study do not differ greatly from those of Miller and Ridolfo; the method, however, can be seen to have disadvantages. Thirteen of the 50 cases of diabetes mellitus would have been missed entirely if the skin test alone had been used. Three of the cases, however, were identified by the skin test when neither the urine nor the blood sugar would have indicated the condition. It seems that if one obtained a positive skin test, he necessarily would be required to do further studies, and that if he obtained a negative skin test, he likewise would be required to do further studies, since the incidence of false negative skin test is significant (over 50 per cent in the 50 diabetics studied).

Summary and Conclusions

Fifty persons with diabetes mellitus and 50 control subjects were studied simultaneously with the glucose oxidase skin test, urine test for sugar and blood sugar level. Three diabetics had positive skin tests when the urine was free from sugar and the blood normoglycemic. Twenty-seven of the 50 diabetics, however, failed to give positive skin tests. Of the 50 control subjects, 36 had negative skin tests, glucose free urine and normoglycemia. Eleven control subjects had a positive skin test, no glucose in the urine and normoglycemia. Of these, 4 were subjected to the standard oral glucose tolerance test. Of this number one curve was probably diabetic, and one was frankly abnormal. It appears that the skin test is positive more often in diabetics than in nondiabetics; its usefulness as a diagnostic tool, however, is doubtful.

Table 2

Results of Tests in Diabetes Mellitus Group

No.	*Skin*	*Urine*	*Blood*
13	neg.	pos.	pos.
3	pos.	neg.	neg.
11	pos.	pos.	pos.
10	neg.	neg.	pos.
2	pos.	pos.	neg.
7	pos.	neg.	pos.
4	neg.	neg.	neg.
0	neg.	pos.	neg.
50			

Table 3

Results of Tests in Control Group

No.	*Skin*	*Urine*	*Blood*
0	neg.	pos.	pos.
11	pos.	neg.	neg.
0	pos.	pos.	pos.
2	neg.	neg.	pos.
0	pos.	pos.	neg.
0	pos.	neg.	pos.
36	neg.	neg.	neg.
1	neg.	pos.	neg.
50			

Table 4

	Name	*Hr.* 0	*Hr.* ½	*Hr.* 1	*Hr.* 2	*Hr.* 3
1.	Sav. vf*	91	145	129	116	
2.	Ive. vs†	71	106	122	103	65
3.	Pri. vs	81	124	173	119	94
4.	Kea. vs	52	129	167	130	

*vf: Venous blood; Folin-Wu method
†vs: Venous blood; Somogyi-Nelson method

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Pre-Commencement Exercises
West Virginia University School of Medicine

Speaker:

Hon. Okey L. Patteson

Former Governor of The State of West Virginia

This is indeed a happy privilege. I well remember when I had the pleasure of delivering the Commencement Address here at West Virginia University in 1949, when I frankly admitted that I never dreamed when I was a green freshman in college, that I would ever be speaking to a graduating class at my own State University.

Being here tonight is even more amazing and surprising to me—because I never dreamed or even imagined that I would ever have the honor of speaking to a group of M. D. candidates at their Convocation when I was working so diligently for the establishment of a four-year medical school in West Virginia; nor when I was burning the midnight oil for many weeks in an effort to determine the proper location for the Medical School.

When one is vitally interested in a project and works tirelessly to complete or accomplish it, then naturally it becomes very dear to him. That is exactly the way I feel about the West Virginia University School of Medicine. I shall never forget the thrill I experienced at the ground-breaking ceremonies of this School, in December, 1952. I stated then that I had worked so diligently on the project, and had been so interested in it, that I felt like a proud father; and that I never thought I would ever be so thrilled over the lifting of a shovel-full of dirt. Dr. Irvin S. Stewart, the President of the University at that time, and Dr. Edward J. Van Liere, the "Daddy" of the two-year medical school and the "Granddaddy" of the present Medical School, as well as the others present on that occasion, whose hearts and souls were in this endeavor, were just as happy and overjoyed as I was. It was indeed a grand occasion!

This great Medical School is very close to my heart, and I shall always be interested in it and its graduates. Also, I might add, that I really appreciate your University Hospital, as I underwent surgery there two years ago and I never saw a hospital operated so efficiently; and the patient-care, in my opinion, was as perfect as any one could hope to achieve.

This is most assuredly a great day for you and you should feel very proud and important! It is needless for me to point out the fact that the profession you have chosen is of the utmost importance and can never be over-estimated. You are well aware of the grave responsibilities which are yours, as you have the privilege of bringing into the world new lives, of curing the ill and of prolonging life. To an extremely ill patient, you will be the most important person in the world!

Being a doctor does not mean that you will only heal the sick; but you will be a person set aside, so to speak. People view their doctors with something akin to reverence, and you must live up to those high expectations because knowledge alone will not save lives. You must instill faith and respect in your patients so that you can help with problems not directly connected with their illnesses, but which indirectly affect their health.

Your profession is much the same as that of a minister of the gospel. We all expect more of him than of an ordinary layman. So, it is with M. D.'s—more is expected and demanded of them. They have a God-given opportunity to care for the ill, and at the same time make life better for their patients. They also occupy a place in the community which makes it possible for them to engage in worthwhile civic activities and other projects; and the local citizens, having the utmost faith in their doctors, will heed their advice and follow their recommendations for better government, improved civic opportunities and other projects and endeavors that make for a better community.

Yes, a doctor's life is difficult but I do not know of one that is more rewarding. What possibly could be more satisfying or heartwarming

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Presented at the pre-commencement exercises for senior medical students at the West Virginia University School of Medicine in Morgantown, W. Va., May 31, 1964.

than the saving of a life, or of bringing into this world a newborn baby? I expect that hardly a day will pass that each of you, as an M. D., will not meet a new challenge. Sometimes it will be most gratifying and, at other times, it will be heartbreaking. Your Medical School has already prepared you to meet the problems and challenges of being a doctor—a *good doctor!*

But there is one thing sure and certain—a great deal is expected of a physician. In fact, you must always remember that more is expected and demanded of you than of any other profession, except perhaps the clergy.

I have heard physicians, nurses and other professionals discuss the television shows which pertain to their special skills, such as "Doctor Kildare," "The Nurses" and other medical shows; and in the instance of the lawyers, "Perry Mason" and others that involve the legal profession. Regardless of whether or not you approve of the TV medical stories, let me assure you that the viewers are greatly impressed with the unlimited time and devoted attention the patients receive from Doctor Ben Casey, Nurse Liz Thorpe, and others.

You know, in my job as President of a Bank, I see people all day and naturally I am connected with many organizations and attend numerous meetings. Sometimes they seem numberless! Each week, I come in contact with hundreds of people in all walks of life and even those who do not like the medical shows, join with the admiring horde who do like them, in proclaiming that our doctors should adopt the attitude of the actors who are so convincing in their portrayal of the active personal interest in each and every patient. The TV doctors are never too busy to give extra time and care to a patient, and they are deeply concerned with his every problem.

Now I know that our doctors are dedicated and attempt to give wholeheartedly of their knowledge and of themselves to their patients; but sometimes they have an overload of patients, and their time is so filled that it is impossible to follow through so diligently and thoroughly as the actor doctors do with each patient. However, I have heard the criticism many times that some doctors do not give more time to the patient because of his golfing, his interest in some business concern, in politics, or some organization. This is a danger which you doctors must guard against, because while you can be invaluable in community work and in sponsoring worthwhile projects, you must avoid becoming too involved. I know, however, that this outstanding Medical School has instilled in your minds and hearts the obligation you owe each patient and I am confident you will never neglect a patient for selfiish or personal activities.

Nevertheless, please believe me, you doctors of today are expected to be extremely concerned with each patient, and to give each one more time, consideration and help, and to be especially sympathetic to his illness and all his problems—even to the point of curbing your own relaxation and outside activities. Whether the medical profession approves or not, the fact remains that every M. D. is expected to be a combination Doctor Kildare, Dr. Ben Casey and the numerous other doctors portrayed on our television screens. This is not only my opinion but it is the belief and idea of hundreds of thousands of your fellow citizens. You may be reluctant to believe that, but, nevertheless, it is true!

I am not here tonight to attempt to give you great words of wisdom. It would be presumptuous for me to even think that I were capable of that. I am just here to talk things over with you—sort of let our hair down, in a manner of speaking.

The Role of Religion

Of course, the greatest help to you as a doctor will be derived from your religious beliefs, which is true of all men and women. You must apply the great truths of religion to every-day life. One of our country's most outstanding brain surgeons has put spiritual values to work in the operating room. Before every operation, he prays silently. He does this for the same reason that he gathers around him the finest group of assistant surgeons available. He says that he would be foolish if he did not avail himself of the help of God, the greatest physician of all.

Yes, your religion is especially important and vital to you and your work; and the knowledge that you can call upon God at any time should be of the greatest comfort to you in your work of saving lives. This knowledge of God's presence should fill you at all times with a feeling of the deepest gratitude, and that gratitude should include your profession, your life, your family, your State and Nation and everyone with whom you are associated. Gratefulness will prove to be one of your biggest assets and is a "must" if you are to attain a truly successful and happy life. Cultivate the habit of thankfulness, and the whole world will be more meaningful.

Now, suppose we consider a few of the most important principles upon which a doctor should base his life—which also could apply to all of us.

One of the first requisites is that a person must have a well-balanced sense of humor. In fact, without such, no person's character can develop fully. Too many people spend a great portion of their time worrying about too many things. You must learn to enjoy a good laugh at your own expense. I don't mean that you should have a sense of humor that permits you to laugh at others; for if you laugh at the troubles and misfortunes of others, your character is lowered. But if you can laugh when things go wrong, appreciate the joys of living and take in your stride your every-day troubles, it will be a good life for you, your patients, your families and all those around you. Every time a man smiles, and even more so when he laughs, it adds something to real living. So, blessed is the man who does not take himself too seriously. Even in so vital a profession as yours, you must develop a good sense of humor.

Making Good Use of Your Time

Then, there is the power to make good use of your time. Show me how a man or woman spends his or her time, and I can tell you something about the character that lies behind that person. Today, institutions, philosophies of government and whole populations are changing in character, opportunity and thinking—almost overnight. In my lifetime, we have graduated from the horse and buggy to the transcontinental airways and jet propelled planes; from the ice house to air conditioning; from the slow mail to the telephone, radio and television. Men have orbited the earth and we are receiving and transmitting by satellite around the world. These are times of great changes and the person is lost who does not attempt to bring all parts of his life together into some kind of worthwhile pattern.

A famous American educator once said: "It is more than probable that the average man could, without injury to his health, increase his efficiency fifty per cent." Try it sometime. Make a list of a few things that you would most like to do. Put down such items as time spent in silence, in cultivating friendships, in reading great literature, and in helping others with their problems. Check your list later and see just how much time you have literally thrown away. Time is a fabulous wealth which all possess and too often neglect by permitting precious hours to slip away, never to return, unredeemed opportunities that are lost forever—great experiences which we shall never know. How do you spend your time? Of course, you would probably answer by stating that the Medical School professors have been keeping all your time occupied for the past few years. But stop and take inventory and you will be amazed at the time you have wasted.

Then, you must achieve the power to live beyond yourself. How many men and women do we know who are unable to yield to the demands and wishes of others, and are almost brutal when they are denied their own petty desires. Think of all the people who have no ability to live beyond their own little selfish world. Is it any wonder that today we have nations and people who are self-seeking, who are war-like, who are suspicious, who cannot understand any problems except their very own?

Yes, the ability to live beyond one's self begins not in international relationship—but it begins in your life and in your mind.

I shall always remember the disaster which befell the ill-fated Italian Expedition to the North Pole many years ago, when the crew of the airship was stranded in the frozen wastes. While the world waited, a seaplane was launched from a rescue ship which had plowed to within a hundred miles of the shipwrecked crew. Soon, the aviator radioed that he had sighted the survivors but that ice was forming on the propellers and wings. Next came the faint radio message that he had made a forced landing and wrecked his plane. The ship radioed, asking his position so that he might be rescued. The aviator's reply stirred the souls of men around the world—"Never mind me. Save the others."

Yes, the power to live beyond one's self is of the utmost importance to you, your patients, your family and those with whom you work. To live beyond yourself is to practice the Golden Rule; and this you cannot do unless you are truly and genuinely humble, which is a quality that should govern every person's life. True humility brings happiness to you and all those around you.

Next, we must have the ability to think independently. No person's mind should be permitted to dwell on prejudice and tradition, and not be able to arrive at its own convictions. A mind must make a decision and hold it.

Everybody must have the ability to think independently—to think courageously—in matters of religion, education, politics, morals and in every aspect of life. Too many people place a high premium upon conformity; upon doing what somebody else does—or thinking as somebody else thinks.

Every person must have the ability to live honestly and truthfully. Without this, the other character-building factors are of little value. No man or woman can set out to perform a great task, or graduate from medical school, without months, even years, of intense discipline of mind and body. And it is true that a man cannot emerge victorious from an experience of sorrow

or master a trying disappointment or vexing problem, until he has made himself live honestly and truthfully. A person cannot learn too soon in life that the worth of a human being cannot be measured by the yardstick of materialism. It doesn't matter how much money you have, or what kind of clothes you wear. A man may possess unexcelled wisdom, or be the wealthiest man in the world; but if he has built his life on a falsehood, all else is meaningless. Men know that truth and honesty are more precious than fine appearances. To have lived truthfully and honestly with yourself and with your fellowmen, is to have lived like a real man!

Take these all-important principles—apply them to your own life—then judge for yourself your standing today. If you have these qualities well cultivated, you are on the high road to success—and most important of all—to happiness. Armed with a sound education, a sense of humor, the ability to make good use of your time, the power to live a little beyond yourself, the will to think independently and to live honestly and truthfully—you do not belong to the world—but the world can belong to you.

Yes, the world can belong to you. But there is one further thought which is very important. Don't labor under the false impression that you can get something for nothing, because you will find (if you have not already done so) that to attain the success and happiness of which I have spoken, you must give something to the world in return.

You are already in debt, even before your internship begins. I am not referring to a debt from a monetary standpoint—but today as you leave the portals of this great University Medical Center, you have a deep and high moral obligation to this institution which you have attended. I am confident that you will always meet life's problems, and conduct the business, political and social affairs of your community, your State and your Nation, in a manner which will cause those about you to say, "This Doctor's life and course of conduct were first framed by a great Medical School, by the generosity of the citizens of West Virginia; and hence, it is no small wonder that success, happiness, public respect and acclaim are his."

Always bear in mind that the opportunities which the people of West Virginia have made available to you in these great halls of learning should never be considered by you as your right. It is and was your privilege. From now on, you cannot say of the West Virginia University School of Medicine and of this State—"What do they owe me?" That has already been answered. In the future, the only question of indebtedness in your mind should be—"What can I give my Medical School and the State of West Virginia?"

Give your Medical School a generous portion of your heart, give it a part of your time, give it a life of outstanding conduct and achievement. You have needed the School and it has served you well. From now on, remember that your Medical School needs you.

Never let the ties which bind you to this great School be severed through neglect, through indifference—or even distance. With your warm, affectionate and continued support, this Medical School can continue its great and rapid growth in the years to come; and through that, and hence through you—countless other young men and women can some day be blessed with that opportunity which you have thus embraced; and they can look forward, at some future time, to sitting in those places which you now occupy—ready to face the world, ready to make the world theirs, ready to be better citizens and ready to be the best Doctors—just as you are today. It was through the loyalty, the sacrifice, the faith, sometimes of a very few people, but more often of a great many, that this Medical School was born, that it has lived, and that it has reached its present high place. Surely, this in itself is a challenge which I know every one of you will accept and fully meet.

I was highly pleased to read in a Charleston newspaper some few weeks ago that fifteen members of this, the third class to be graduated from the West Virginia University Medical School, would intern in West Virginia. What better way can you prove your appreciation of this great Medical School than by serving West Virginia citizens? I could not help but wish that all the members of this class were planning to intern in West Virginia hospitals. Our State needs doctors very badly and we offer you a vast opportunity for service. I strongly urge that you take advantage of establishing a practice in West Virginia when you have completed your internship, or that you become affiliated with one of our many fine hospitals.

It is my prayerful hope and sincere belief that as you go forward to pursue your vitally important profession, that your life will assume a deeper and richer meaning—not only to you, but to your patients, your fellowmen, your family and all those with whom you are associated.

You have my most sincere and best wishes for your every success; and may you go forward—never look backward—but look ever upward and onward. And may God's richest blessings be yours always!

Medicine in Retrospect*

Norman A. Welch, M. D.

PERHAPS it is the aging process at work, but it seems to me that one of the favorite pastimes of my colleagues of late is marveling at medicine in retrospect. Certainly, I am as guilty of this as anyone. Still, I cannot help but view medical progress with considerable awe. I have to extend myself so much keeping up to date.

Most of the medicine we now practice was not taught us by our professors. Not that they were not good professors. To me, at the time, the grasp of their knowledge seemed beyond the capabilities of mere humans. But they could not teach what did not exist and the things that make medicine modern simply were not known a scant generation ago. In fact, many facets of today's practice were not available less than a decade ago when students grappled with my dissertations.

By now most of you probably have scanned the report of the Commission on the Cost of Medical Care. Many of you perhaps were drawn immediately to Volume Three—the one headed "Significant Medical Advances."

This volume devotes page after page to listing the accomplishments of the past quarter century. But what dreamer 25 years ago would have had the courage to predict such advances openly—the procedures and events, the drugs and instruments that today are part of the ordinary practice of medicine? He would have been greeted with laughter, or a sanity test, for the spin of progress has been so fast that what is now common was then imperceptible.

Why is this so? What has transpired? How is it that medicine has out-paced every science, including rocketry, which after all goes back to ancient China? The answer, I think, is found in the fact that medicine is never satisfied—that responsibility lies heavy and that all we could possibly offer would in toto never be quite enough, at least as far as we are concerned.

This realization is surely another great measure of medical progress, though it does not meet the criteria for listing in the Commission report. Nor does still another advance qualify—medicine's adaptability to change. Yet, in my estimation, this ability to change ranks equal in importance with the fact that medicine has changed.

The Author

- **Norman A. Welch, M. D., Boston, Massachusetts, President of the American Medical Association.**

'A Quiet Revolution'

With the advantage of hindsight, then, we see that medicine has undergone a quiet revolution. It has broken free of static hypothesis and instead ranges the scale of human events. It has exchanged singleness of purpose for plasticity.

In the process, the utopian dream of making medicine an exact science has been exposed as a myth. Instead, we see medicine for what it really is — a compound; a conglomeration of science and economics, fact and theory, precision and educated guess, teamwork and solitary responsibility.

We also perceive that freedom to adapt is more precious and the right to responsibility more important than we ever dreamed a quarter century ago.

Always, it seems, we come back to responsibility and rightly so; for medicine is responsive to so much — to mankind's general susceptibility to disease, to the needs of the patient as an individual, and to those who have given us the profession and art of medicine.

I believe that we are meeting these responsibilities. I believe we have shown an ability not only to keep pace with the unprecedented past, but also to accelerate that pace. I believe we have accepted the mandates handed to us by the molders of medicine, and we are willing to pass them along, suitably amended, to the next generation of patients and physicians.

Accomplishments

How can I believe otherwise when I reflect upon what has unfolded in the year culminating in this meeting? Not the thrusts and parries about which headlines battle, but the truly solid accomplishments. Things such as:

Mental health — the development and implementation of broad-spectrum approaches to the

*Presented before the House of Delegates of the American Medical Association during the 113th Annual Meeting in San Francisco, California, June 24, 1964.

treatment and care of the mentally ill and mentally retarded. Throughout our nation, local medical societies are taking the lead, involving all of medicine rather than certain specialties, in overcoming these important problems. More and more the attack is being centered within the community, utilizing local hospitals, centers, clinics, and most important, the family physician's office. As a result, the handling of mental illness is drawing parallel to the handling of physical illness — truly a significant step forward.

Then there is medical education — the development of a program capable of disseminating advanced medical knowledge wherever medicine is practiced.

Consider: For the first time a professional society is preparing to offer its full membership a continuing education. This is no short course in this or that aspect of some specialty. This is a true opportunity for a lifetime of learning, with depth of concentration and sweep of curriculum. This is a uniquely new form of postgraduate education, geared to an electronic age.

Or consider economic research and the report I have alluded to previously on the ways and wherefores of medical advances. The true value of this commission report, of course, is not that it provides a recent history of medicine. Its true value is the fact that it gives us a reliable basis on which to act; on which to determine the true economic structure of medical care and how that structure can best be reinforced so that there will be no slippage in the highest quality of patient care ever known.

Understandably, perhaps, the proponents of that so-called "greater society" want to expound their own course for medicine. Parenthetically, as far as I am concerned the political intrigues to corner medicine are not entirely unflattering. Indeed, they speak eloquently for the accomplishments of a wholly free medical society. For what the political inspirationists behind so-called "medicare" really see in medicine is an excellence which they desperately want to attach to their own tattered image.

Medical Research

The final aspect I should like to probe in considering medicine's responsiveness to responsibility concerns medical research.

Few can help but be impressed by the results of research — flying to the moon, opening a beating heart, probing the imponderables of the atom, or plunging a cannula into the brain of a conscious individual. Yet few indeed understand research, and particularly medical research.

For proof of this you need look no further than the disease-oriented research into smoking sponsored by AMA-ERF. Announcement of this significant research was another important step forward by the American Medical Association during the year. Yet it was greeted by scoffs and twisted into a political bludgeon by the uninformed and the professional ax-grinders.

We know all we need to know about smoking and health, they contend. Medicine merely is seeking to hide its shortcomings with a nefarious smoke screen, they cried.

Where, I ask you, is the smoke screen in knowledge? What plot is there, other than the downfall of disease, in providing grants to help determine the action of nicotine on cells; the relationship between cigarettes and cardiopulmonary disease; the effects of smoking on the ability of the lungs to clear foreign particles; the addictive qualities of nicotine, and whether this substance acts as a stimulant or tranquilizer? How can we possibly know all there is to know about smoking, when science is still asking so many questions?

There is more to such research than answering critics, however. There is in it an element of the revolutionary forces which have so quickly changed the face of medicine.

Medicine on the Offensive

Once the physician was an observer of signs and a treater of symptoms. This is no longer necessarily so, for medicine is going over to the offense. Instead of waiting upon disease, the physician now seeks to anticipate it, prevent it and cure it. For example, we no longer seek merely to contain a local epidemic. Rather we root out the disease, destroy its sources, strive to wipe it from the face of the earth—to obliterate from the human race the microorganisms and deficiencies that breed epidemics.

This concept, this long dreamed-of idea — disease eradication — is not yet an accomplished fact, certainly. But neither does it necessarily belong to the future of medicine. To a large extent it is the here and now of medicine — part and parcel of our dealings with such things as smallpox, tetanus, yaws, rickets, yellow fever, malaria, measles, polio, influenza, plague and syphilis.

In many instances, of course, we are still forced to accept a defensive role — to treat symptoms rather than disease. But we do so grudgingly and with reservations — with the clear understanding that some day we will no longer have to react to certain diseases but instead can initiate action.

This, after all, is the future of medicine.

The future, however, is not limited to some place in time a decade or century from now. It begins tomorrow and is based in the biological research of today.

As a nation we are, perhaps, too over-anxious, too eager to jump into the future with both feet before we really know whether we are plunging into an exhilarating pool or a mire of quicksand.

This will not do for medicine. We may be damned for our timidity if we do not jump, or we may be damned for not having better sense if we do jump. But the important thing, I believe, is this: While we cannot always be positive where we are going to land, as physicians we at least know when and why we are jumping.

Institute of Biomedical Research

I can think of no better illustration of this than the AMA-ERF Institute of Biomedical Research, which is preparing to open in the coming year. We know that the basic type of research that will be conducted at the Institute is necessary, and that it is needed now. We cannot, however, say with exactness what we expect to find. Our leap in this case has left us in mid-air; and that is as it should be, for otherwise we would not be sponsoring good research.

In a way the Institute itself is somewhat of an experiment — an extraordinary undertaking in this day and age. This uniqueness goes beyond the Institute's dedicated purpose of "fundamental inquiry into the life process on all basic levels." It penetrates right into the fundamental workings of the program. For as conceived, and as now being implemented, the Institute will offer a real opportunity for the creative minds of research to work unfettered by unwanted obligations, grantsmanship or the supposed expediency of "crash" programs.

That such a course will be followed seems assured, considering those who have already agreed to serve on the Committee of Scientific Advisors to the Board of Directors of the AMA-ERF — William H. Feldman, America's elder statesman of experimental pathology; Chauncey D. Leake, Department of Pharmacology, University of California School of Medicine; D. D. Van Slyke, Father of Modern Biochemistry, and Maurice B. Visscher, Department of Physiology, University of Minnesota.

I said before that we could not set with exactness the goals of research. It also should be clear that we have no desire to do so. This does not mean, however, that our interest is secondary, or that the future is unknown. For we do know that basic research leads first to a better understanding of life mechanisms and then to a better understanding of the aberrations of those processes — aberrations we know as disease. This in turn opens out new, more reliable forms of diagnosis, better therapy and, perhaps, better cures for disease — the ultimate hope that springs from a juncture of medicine and research.

In the minds of many, these two — medicine and research — are co-related into one, medical research. While they do overlap, grossly at times, to me their kinship is not that of Siamese twins.

To a large extent the biological sciences — those sciences most intimately connected with man — are an outgrowth of medicine. For centuries physicians were not so much the beneficiaries of this research as the chief contributors to it. Out of the astute practice of medicine came descriptions of body functions, understanding of disease and techniques for physiological exploration—the particulars that enabled biology to begin the exploration of life.

Molecular Biology

But now the science of medicine has gone beyond the gross descriptive phase. It has evolved logically, if somewhat paradoxically, into smaller things — cells and molecules. Into this realm of "molecular biology" the physician has difficulty following, for he possesses neither the time nor the elaborate equipment necessary to explore the molecular interchanges that are the processes of life.

And so it is now the researcher who largely provides medicine with the basics of good practice, rather than the good practice of medicine supplying the basics to research, as once was the case.

There is a dilemma here. If I as a practicing physician cannot contribute much knowledge to the new order of basic research, neither can "biomedical research" provide me with much that is immediately practical and useful to the practice of medicine.

The fact that a DNA or RNA molecule is apparently a doublestrand helix has not one iota of importance to me as a practicing physician. This knowledge, so painstakingly come by, does not help me in the least to diagnose a disease, prescribe a drug, set a broken bone or perform an appendectomy.

I am not immediately concerned with an individual cell of one of my patients. I am concerned with the whole patient; his mind, his body, his well-being and his life. But to the man attempt-

ing to define life and living, the individual cell is of utmost importance.

While I excise a whole organ, he excises the nucleus of a single cell. While I trace the course of an intricate compound known as blood through a diseased heart, he traces the course of a basic RNA molecule to a ribosome within a cell. While I speak of anatomy and function, he speaks of elemental particles and mathematics. While I seek results, he seeks more unknowns.

Certain aspects of medicine and research, then, obviously operate at different poles. Furthermore, the philosophy of one sphere is often divergent from that of the other.

Does this mean that medicine and basic science are growing apart? Are they becoming incapable of translating to one another? The answer is no, for the physician cannot be all practical nor the researcher all theoretical.

While the shape of molecules may have no meaning for me as a practicing physician, it has a profound impact upon me as a member of the medical community. It indicates that perhaps some day I may be able to repair the crossbar of a spiraling RNA ladder with an enzyme injection and so prevent a tumor growth or a malformed brain.

As for the researcher, no matter how pointed his quest for pure science, his roots in the community of man cannot help but make him hopeful that his work will ultimately find its place in the benefit of human life.

An Alliance

So rather than a divergence, we have an alliance — an alliance rooted in truth, knowledge and the freedom to search them out.

These are the greatest assets available for human development and human well-being. And they are available only when the mind of man is not pinned to a doctrinal shirt-tail or warped by a bending of truth to match doctrinal expediency.

We may be harangued for not falling into the niche shaped for medicine by conceptional architects. But we do not have to harangue ourselves for permitting the highest type medicine known to the world to become encapsulated in a bitter pill of socialism. Nor will we ever as long as we continue to act rather than react — as long as we strive for eradication of disease and eradication of those foreign concepts that would stifle medical progress.

That is why to me, this past year in the American Medical Association has been one of the most exciting I have known. It is a year in which the weld between medicine and research, medicine and education and medicine and people has been overlaid with new understanding and new questing after truth and knowledge.

We have acted. We shall continue to act.

We have come far in the past quarter century. We have come far in the past year. But we have not come so far that, like Leeuwenhoek peering into the wonderful lens of his new microscope nearly three centuries ago, we cannot help but marvel at how much is yet to be explored.

Old Issues Out

In the ideal office, one patient would be entering just as the previous one leaves. There would be no need for chairs, lounges, magazine racks and similar equipment in the waiting room. However, this ideal is seldom attained. The physician prepares for this delay by having room for waiting patients and various persons who accompany them. To help them pass their time with less fidgeting, periodicals are provided. When the patient picks up a copy of a magazine, he is all too often reminded of ancient days. The copy may well be more than three or four years old. This situation has been the butt of jokes for many seasons.

Just as the physician wants the latest equipment and up to the minute knowledge for treating his patients, he should want his waiting room to be up to date. This is easily done. Buy new magazines. At the end of the month, throw out all the old issues. Automatically, this keeps the reading material up to date and mollifies the patient who has been kept waiting. After the first month, the job is relatively easy.—Massachusetts Physician.

The President's Page

THE YEAR AHEAD

As I became your 98th President at The Greenbrier, I visualized many of the men who had preceded me in this long chain of devotion to our profession and was filled with a deep sense of humility. I earnestly hoped that I might continue the tradition of the past in the fulfillment of the duties of this office. I am most grateful for your trust but am also aware of the great responsibilities that lie ahead. With the aid of Almighty God and each and every one of you, our tasks can and will be accomplished.

In the year ahead, there remain many unresolved legislative and medical society problems on a national, state, and local level—you know them well.

Legislatively, the fundamental problem revolves around the socialistic attempt to subjugate medicine. The achievement of a unity of purpose and action should, therefore, be of paramount importance to counteract these outside forces, especially in this, an election year. Only by such unity of purpose and action can we hope for success with many of our problems.

In the coming national, state, and local elections, I urge you to become active participants. Our responsibility to our community no longer ends at the door of our consultation rooms; we must add to our skillful practice of the science and art of medicine, the socio-economic and political aspects of medicine.

With deep gratitude to Dr. Charles L. Goodhand and the many workers in both our Association and the Woman's Auxiliary for a job so well done last year, may I ask that each of you in our Association unite with a determined unity of purpose and action in order that we might achieve our goals in the year ahead.

Albert C. Esposito

Albert C. Esposito, M. D., President

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EDITORIALS

REMINISCING AND OLD AGE

As people, especially men, grow older, they are likely to engage in reminiscing, a trait defined as the act or habit of thinking about or relating past experiences. Reminiscing is not necessarily limited to senescence, but it is characteristic of this stage of life, and it contributes to the impression that old people live in the past. Older people like to talk about their youth, their accomplishments, their illnesses, their sorrows and failures. The habit seems to be almost universal.

The younger generation who, after all, have not yet accumulated much of a past to draw upon, do not understand the reminiscing of older people, and with the natural intolerance of youth, often regard this trait as a symptom of presenility or senility. This critical view apparently should be somewhat softened in the light of present day research on the subject.

Recently an interesting psychologic study was reported on reminiscing in older people by McMahon and Rhudick.[1] The study was made on 25 non-institutionalized Spanish-American War veterans between the ages of 78 to 90. The tendency to reminisce was compared in each subject with (a) the degree of intellectual deterioration, (b) the presence or absence of depression, and (c) survival since the interview.

The findings suggested a positive correlation between the tendency to reminisce and freedom from depression and survival (two years) since the interview. Reminiscing was not related to intellectual deterioration. In fact, the conclusion was drawn that in some ways reminiscing may contribute to successful adaptation. It was observed further that old people who are mentally depressed show less tendency to reminisce.

The presence or absence of depression is undoubtedly an important factor. One year after the completion of all the interviews a re-snrvey was made of the group to determine how many had died in the interim. It was found that three of the four subjects rated as depressed had died, and four of the five subjects rated as suspected depressed had died also; however, only one of the 16 subjects rated as not depressed had died. Statistically these figures were significant at somewhat better than the 0.01 per cent level.

It is gratifying to older people to know that reminiscing does not necessarily indicate a senile state and to realize, also, that the tendency to reminisce is definitely related to successful adaptation. Indeed, McMahon and Rhudick suggest that older people be encouraged to reminisce and that occasions be created for this purpose.

Why do older people reminisce: Psychologists list a number of reasons, among which are: reminiscing is an attempt to fill in the void created in the present by failing memory; it serves as a constant reminder to himself and to

1. McMahon, A. W., and P. J. Rhudick: Arch. Gen. Psychiat., 10:292 (March) 1964.

others of his achievement of longevity; it is a facet of self-centeredness which enhances with old age. Some relatively simple explanations may also be offered. Older people reminisce because they have more leisure time at their disposal, or they feel that they have experienced and seen so much that they believe others may profit by hearing about it, or they may just be lonesome. Whatever the cause, a natural-born story teller, when recounting past experiences and exploits can be entertaining and informative.

A word of warning may be suggested concerning older people who reminisce excessively. However tolerant we may be with this type person, some appear to live wholly in the past, and manifest but little interest in the present and even less in the future. These people should be gently urged to turn their attention to less remote periods, and encouraged to appreciate and participate in the joys of the present.

THE COST OF MEDICAL CARE

Volume I of the Report of the Commission on the Cost of Medical Care from the AMA is now available for study. It offers a comprehensive definitive analysis of the cost of private and hospital care. It begins "The physicians of America are the primary members of a health team which provides the highest quality of medical care in the world. In addition to their concern with the advancement of scientific knowledge and improvements in the quality of medical care, physicians realize and appreciate the natural concern of the public with respect to the amount it spends for health services."

The purpose of the study is to obtain information descriptive of health care trends at the national level in the past 15 years.

The personal consumption expenditures for private medical care shows an increase from $2.2 billion dollars in 1935 to $22 billion dollars in 1962—but this was only a slight increase when related to disposable personal income—an increase from 3.9 per cent to 5.7 per cent.

In the same period the total number of physicians increased from 156,406 to 265,408 but the percentage in private practice decreased from 85.9 per cent to 64.5 per cent and the number in hospital services, teaching, administration, industry and government service rose from 14 per cent to 35.5 per cent.

Hospital beds showed an increase almost commensurate with the increase in population but there was a 35 per cent increase in utilization of the beds. In the same period the percentage of civilian population with some form of hospital insurance increased from 30.3 per cent to 76 per cent of the total population in 1962.

As an indication of the disposition of the health dollar it should be noted that the average charge per hospital day was $9.39 in 1946 and $36.83 in 1962. Although more patients are seeking hospitalization the average length of hospital stay decreased from 9.1 days in 1946 to 7.6 days in 1962.

The most frequent cause of hospital admission continues to be delivery, followed closely by that summer complaint of T & A.

All physicians interested in that perverse subject of medico-socio economics can read this report with interest and more than likely prove thereby all their own theories of the cost of medical care.

Health Insurance Coverage

Over the last 20 years, the number of people protected in the United States by some form of health insurance has gone from one out of every five to more than three out of every four persons, the Health Insurance Institute reported recently.

In 1943, 19 per cent of the U. S. civilian population were protected by some form of health insurance, while at the beginning of this year 77 per cent of Americans were so covered. At the midway point, 1953, some 61 per cent of the population had health insurance.

Twenty years ago, only 24 million Americans were covered by hospital expense insurance. Since then there has been a six-fold increase and over 145 million persons were protected against the cost of hospital care at the year-end 1963, by insurance companies, Blue Cross-Blue Shield, and other plans. In 1953, over 97 million were so insured.

The Institute said this explosive growth can be attributed to many factors, among which is the public's growing awareness of the value of modern health care and its need to find a mechanism to help prepay the cost of such care. The same type of growth has been shown, said the Institute, by other forms of health insurance. In 1943, 10 million Americans had surgical expense insurance, but in the following 20 years there was a 13-fold increase and at the end of 1963 nearly 135 million persons had protection against the cost of surgical bills. In 1953, nearly 81 million persons had surgical insurance.

Regular medical expense insurance covered over 3 million Americans in 1943. There was a 30-fold increase in coverage in 20 years so that more than 102 million persons were covered last year. In 1953, close to 43 million persons were so protected.

GENERAL NEWS

17th Annual Rural Health Conference At Jackson's Mill on Oct. 1

Dr. Paul A. Miller, President of West Virginia University, will be the keynote speaker at the 17th Annual Rural Health Conference which will be held at Jackson's Mill on Thursday, October 1.

More than 200 persons are expected to attend the Conference which is sponsored annually by the West Virginia State Medical Association in cooperation with the Agricultural Extension Division of West Virginia University, the West Virginia Home Demonstration Council, the State Department of Health, the West Virginia Farm Bureau and the West Virginia Congress of Agriculture.

Dr. Earl L. Fisher of Gassaway, who is in charge of the program for this year's Conference, will call the meeting to order in the Assembly Hall promptly at 10:00 A. M. (EST). The invocation will be given by The Rev. H. Edgar Suite of Gassaway.

Following the address by Doctor Miller, the remainder of the morning session will be devoted to programs on "Medical Quackery" and the "Immunization Program in West Virginia."

Mr. James L. Trawick of Washington, D. C., Director of the Division of Consumer Education of the U. S. Food and Drug Administration, will present the program on medical quackery.

Mr. Trawick first joined the Food and Drug Administration in 1940 and was appointed to his present position earlier this year. He is recognized as an authority in the field of medical quackery.

The "Immunization Program in West Virginia" will be discussed by Dr. L. A. Dickerson, Director of the Disease Control Division of the State Department of Health, and the other participant will be an official from the Communicable Disease Center in Atlanta, Georgia.

Luncheon will be served in the Mt. Vernon Dining Hall at 12:15 P.M., with the West Virginia State Medical Association as host.

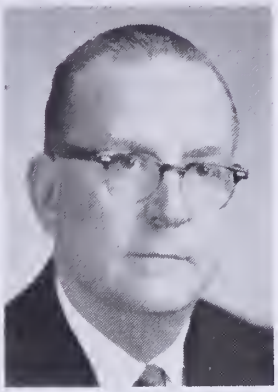
Afternoon Session

Dr. Albert C. Esposito of Huntington, President of the State Medical Association, will deliver the address of welcome at the opening of the afternoon session.

Following his address, Dr. Ernest W. Chick of Morgantown will discuss "Living With Your Disability."

Doctor Chick is Associate Professor of Medicine and Director of the Department of Preventive Medicine at

Dr. Paul A. Miller



James L. Trawick

the West Virginia University School of Medicine. He received his M.D. degree in 1953 from the Duke University School of Medicine.

Medicine and Religion

A physician and a minister from Kanawha County will present a program on "Medicine and Religion." The participants will be Dr. Tracy N. Spencer, Jr., of South Charleston, Chairman of the Committee on Medicine and Religion of the State Medical Association; and the Rev. John S. Lyles, Minister of the First Presbyterian Church in Dunbar.

There also will be a showing of the film, "The One Who Heals," during this portion of the program.

Summary by Dr. Bond L. Bible

The final portion of the afternoon program will be devoted to a summary of the Conference by Dr. Bond L. Bible of Chicago, Secretary of the Council on Rural Health of the American Medical Association.

A graduate of West Virginia University, Doctor Bible was appointed to his present position in 1963. He served for several years with the Agricultural Extension Division of the University before leaving the State.

Advisory Committee

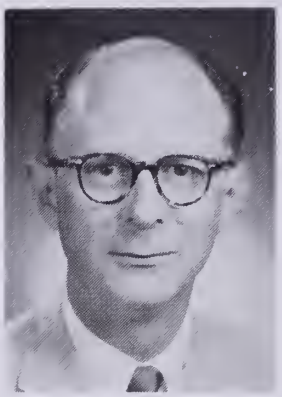
The Program for the Conference was planned by members of the Advisory Committee to the State Medical Association's Rural Health Committee.

In addition to Doctor Fisher, other members serving on the Advisory Committee this year are Miss Gertrude Humphreys of Morgantown, State Extension Home Demonstration Leader; Dr. N. H. Dyer, State Director of Health; Mrs. Charles Elliott of Beatrice; and Mrs. Pat A. Tuckwiller, Immediate Past President of the Woman's Auxiliary to the State Medical Association.

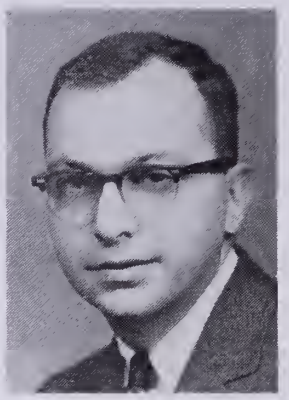
'A Day on Cardiovascular Diagnosis' Theme of Heart Assn. Session

"A Day on Cardiovascular Diagnosis" will be the theme of the scientific session during the annual meeting of the West Virginia Heart Association which will be held at the UpTowner Inn in Huntington, September 3-4.

Dr. A. C. Thompson of Elkins, president elect, will preside at the scientific sessions which will be conducted Friday morning and afternoon, September 4.



Thomas W. Parkin, M. D.



Alan M. Weintraub, M. D.

Members of the American Academy of General Practice will receive 4½ hours credit for attendance at the meeting.

The speakers and their topics are as follows:

"Cardiac Auscultation."—Alan M. Weintraub, M. D., Clinical Assistant Professor, Georgetown University School of Medicine; Cardiac Consultant, Department of Cardiology and Cardiovascular Surgical Service Director, Medical Cardiovascular Clinic, Georgetown University Hospital; and Antonio C. deLeon, M. D., Instructor in Medicine, Georgetown University School of Medicine.

"Electrocardiography."—Thomas W. Parkin, M. D., Consultant in Medicine, Mayo Clinic, Rochester, Minnesota.

"Fundamentals of Cardiac Roentgenology."—Benjamin Felson, M. D., Professor and Director of Radiology, University of Cincinnati College of Medicine and Director of Department of Radiology at Cincinnati General, Holmes, Drake, Children's and Dunham Hospitals.

A panel discussion by the four speakers and a question-and-answer period will conclude the scientific session.

Dr. Otis G. King of Bluefield, president of the Association, has extended a cordial invitation to all physicians in West Virginia to attend the two-day meeting.

Both Doctor King and Doctor Thompson will speak at the annual membership luncheon on Friday when nearly 40 members will be elected to the Association's Board of Directors.

Dr. George E. Wakerlin of New York City, Medical Director of the American Heart Association, will be the guest speaker at the annual banquet on Friday evening.

The meeting will open on Thursday evening, September 3, with a meeting of the Association's board and the annual election of officers.

Convention Story Will Appear In October Journal

The 97th Annual Meeting of the West Virginia State Medical Association was being held at The Greenbrier in White Sulphur Springs as this issue of *The Journal* went to press.

The full convention story, including information concerning new officers of both the State Medical Association and Auxiliary, as well as heads of sections and affiliated societies and associations, will be carried in the October issue.

Significant Changes Were Recorded In Causes of Death During 1963

Significant changes in the ten leading causes of death occurred during 1963 in West Virginia. In his weekly State of the State's Health, State Director of Health Dr. N. H. Dyer discussed important data included in the recently compiled 1963 vital statistics report.

The five leading causes of death for 1962 and 1963 remained the same—diseases of the heart, malignant neoplasms, vascular lesions affecting the central nervous system, accidents, pneumonia and influenza.

Diseases of early infancy, which was not among the leading causes of death in 1962, has jumped to sixth, replacing general arteriosclerosis which dropped to seventh.

Diabetes mellitus dropped from seventh to eighth, replacing congenital malformations. Suicide and nephritis and nephrosis, ninth and tenth in 1962, dropped out of the first ten in 1963. They were replaced by other diseases of the circulatory system and congenital malformations and hypertension without heart disease, which shared 10th place.

Doctor Dyer discussed other items deserving special attention:

Beginning with children, age-5, cancer is the second leading cause of death in all age-groups except 30-to-39 and 60 years or older. Heart disease is second among persons 30-to-39 with strokes in the same category for persons over 60.

Homicide is the fifth leading cause of death in the five-to-nine age-group; fourth among persons 20-to-29; fifth among those 30-to-39; seventh among those 40-to-49.

Suicide first appears as a leading cause of death among persons 15 to 19 years of age where it ranks seventh; it is the sixth-ranking cause in the 20-to-29 group; fourth among those 30-to-39; fifth among those 40-to-49; ninth among those 50-to-59. After 60, it disappears from the leading causes of death.

A total of 19,405 deaths were recorded in the state for 1963 against 18,651 for 1962. Four major causes accounted for 13,611 deaths—70.1 per cent of the total. These include heart disease, 7,606 deaths; cancer, 2,674 deaths; strokes, 2,164 deaths; accidents, 1,167 deaths.

West Virginia University Hospital Names 43 to House Staff

The West Virginia University Hospital has named 43 residents to its house staff for the coming year. The 41 physicians and two dentists receiving new or continuing appointments also hold concurrent appointments in clinical departments.

Dr. Alfred D. Ghapery, 29, of Wheeling, is the new chief resident. He was graduated from Wheeling Central High School and West Virginia University and received his M. D. degree from the University of Pittsburgh School of Medicine. He served a residency in surgery at the Clarksburg VA Hospital before joining the WVU staff in 1961.

Names of the old and new residents, year of residency training, any West Virginia affiliation and college or university where they received their M. D. degrees follows:

Residents in Medicine: Drs. Evangelos K. Apostolou (3) University of Athens, Greece; Young K. Choi (3) College of Medicine, Seoul National University, Korea; William H. Jacobs (3) Jefferson Medical College, Philadelphia; Joseph A. Maiolo (3) of Morgantown, Medical College of Virginia.

Drs. Wayne C. Spiggle, Jr., (3) of Davis, Medical College of Virginia; Robert F. Gustke (1) of Parkersburg, WVU; Lowell T. Mouser (1) of Minnehaha Springs (Pocahontas County), WVU; and Grover R. Tompkins (1) of Charleston, WVU.

Residents in Obstetrics and Gynecology: Drs. Yaroslav Rudawsky (4) Faculty of Medicine, University of Madrid, Spain; and Julio R. Serrano (1), Havana University, Cuba, in 1960.

Residents in Pathology: Drs. Simeon J. Palomino (3) University of San Marcos, Lima, Peru; and Abe Kazuo (3) Tohoku University Medical School, Sendai, Japan.

Resident in Pediatrics: Dr. Myung K. Park (2) Seoul National University, Korea.

Residents in Radiology: Drs. George W. Butz, Jr. (4) Northwestern University; and Francis A. Goad, (2) of Clendenin, WVU.

The following are residents in the various fields of surgery:

Anesthesiology: Drs. Peter Chang (2), Shanghai Second Medical College, China; Norda R. Serrano (1), Havana University, Cuba, in 1960; and Potenciano C. Tampoya (1), Manila Central University, P. I.

General Surgery: Drs. Kenneth E. Thomas (4), Stanford University; Eugene S. LaPlante (2), University of Minnesota; Keith L. Stackhouse (2), Northwestern University; Henry M. Carber (1), Southwestern Medical School, Texas; Leon W. Grimm (1), University of Pennsylvania; Frederick W. Miltenberger (4), Medical College of Virginia; Wihbi A. M. Shu'ayb (4), American University of Beirut, Lebanon; and Marcos Y. Que (3), University of Santo Thomas, Manila, P. I.

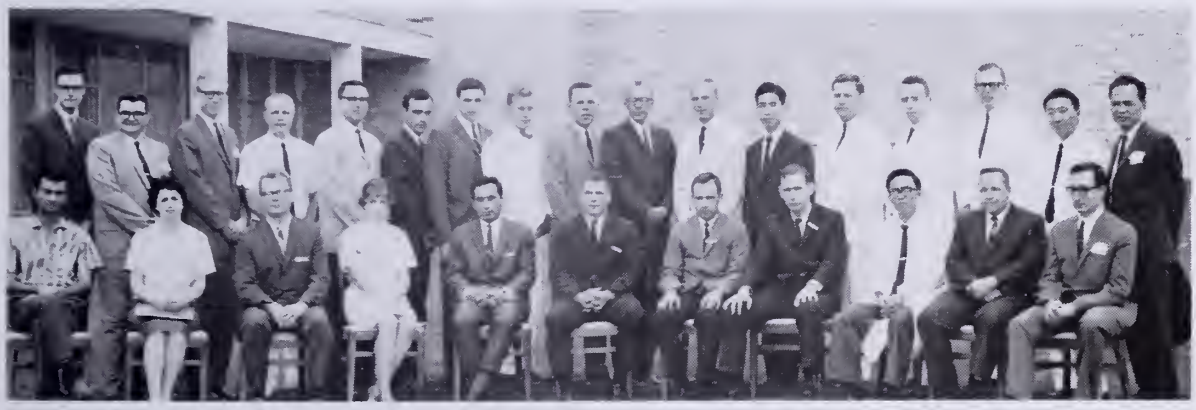
Neurosurgery: Drs. Robert E. Burney, II, (4) University of Miami, Fla.; Hisham S. Majzoub (4) American University of Beirut, Lebanon; Bruce A. Ames (3) University of California; Richard C. Zahn (3) Ohio State University; and Reza P. Asli (1) Teheran University, Iran.

Ophthalmology: Drs. William M. McFadden, III, (2) University of Pennsylvania; and Richard D. Richmond (1) of Beckley, WVU.

Orthopedic: Drs. Karl D. Bowers, Jr. (3) of Beckley Jefferson Medical College, Philadelphia; Colin M. Craythorne (3) Queen's University, Belfast, Ireland; Moosa Kohanim (2) Pahlavi University, Iran; Jack Pushkin (1) of Charleston, WVU; and Victor Cardona (2) University of Madrid, Spain.

Urology: Drs. Arsenio M. Orteza (3) University of the Philippines; and Robert H. Graham (2) Jefferson Medical College, Philadelphia.

Two graduate dentists have been appointed residents in oral surgery: Dr. John B. Haley, Jr., of South Charleston, is junior resident in oral surgery and received his D. D. S. degree from WVU; and Dr. Robert G. Oglivie, is senior resident in oral surgery, and received his D. D. S. degree from the University of Pennsylvania.



Thirty-one physicians, two dentists and one resident in hospital administration have joined the staff at the West Virginia University Hospital in Morgantown. They include, seated, left to right: Drs. Reza P. Asli and Norda R. Serrano, residents; Edwin J. Morgan and Susan Shaw Gustke, interns; Nasser Emani, dental intern; Gerald F. Ronning, Thomas J. Rose and Gary F. Gilbertson, interns; and Marcus Y. Que, William Jacobs and Joseph A. Maiolo, residents.

Standing: Charles Pinkerman, resident in hospital administration; Drs. Julio R. Serrano, Robert H. Graham and Richard C. Zahn, residents; Paul J. Jakubec and James R. Gaskell, interns; Lynn A. Dolan, oral surgery intern; Robert F. Gustke, resident; Phillip J. Ranheim, John A. Reichert, David J. Carlson and Nam Ha Paik, interns; Henry M. Carder, Leon W. Grim, Grover R. Tompkins, Myrung K. Park and Potenciano Tampoya, residents. Absent when the picture was made were Drs. W. Scott Bowie, Anton Vos and William A. Morrison, interns; and Drs. William M. McFadden, Richard D. Richmond, Jack Pushkin, Lowell T. Mouser and Victor Cardona, residents.

Postgraduate Course on Tuberculosis At WVU Medical Center on Oct. 6

A one-day postgraduate course on "Tuberculosis" will be held at the West Virginia University Medical Center in Morgantown on October 6.

The program is sponsored by the West Virginia University School of Medicine and the West Virginia Tuberculosis and Health Association. It is being held in conjunction with the annual meeting of the TB and Health Association in Clarksburg, October 7-8.

Dr. Charles E. Andrews, Professor of Medicine at the WVU School of Medicine, will preside and present one of seven papers during the one-day meeting.

Other speakers on the program include Dr. James W. Raleigh of New York City, Medical Director of the American Thoracic Society; Dr. John S. Chapman of Dallas, Texas, Assistant Dean of the University of Texas Southwestern Medical School; Dr. William B. Tucker of Washington, D. C., Director of Medical Service of the Veterans Administration Department of Medicine and Surgery; and Dr. Richard A. Currie, Assistant Professor of Surgery at the WVU School of Medicine.

The scientific program will be as follows:

9:00—"Pathogenesis of Tuberculosis."—Charles E. Andrews, M. D.

9:30—"The Problem: Tuberculosis in the United States and West Virginia."—James W. Raleigh, M. D.

10:30—"The Transmission of Tuberculosis as Studied in the Family Situation."—John S. Chapman, M. D.

11:15—"A Program for Caring for Tuberculosis Patients in General Hospitals"—William B. Tucker, M. D.

2:30—"Drug Therapy of Patients with Tuberculosis."—William B. Tucker, M. D.

3:00—"Surgical Therapy of Patients with Tuberculosis."—Richard A. Currie, M. D.

4:00—"The Problem of Unclassified Mycobacteria." John S. Chapman, M. D.

Doctor Andrews said there would be case presentations during the morning session.

Pulmonary Disease Symposium Planned in Huntington

The Cabell Medical Society's 10th Annual Symposium on "Pulmonary Disease" will be held at the Frederick Hotel in Huntington on September 10.

The scientific session will begin promptly at 9 A. M. EDT and will be concluded at 5 P. M. There will be no registration fee and additional information may be obtained by writing to the program chairman, Dr. Joseph M. Farrell, First Huntington National Bank Building, Huntington, W. Va.

James W. Raleigh, M. D.

John S. Chapman, M. D.

W. Va. TB and Health Assn. Meeting In Clarksburg, October 7-8

The 44th Annual Meeting of the West Virginia Tuberculosis and Health Association will be held at the Stonewall Jackson Hotel in Clarksburg, October 7-8.

A one-day postgraduate course on "Tuberculosis" will be held in conjunction with the annual meeting at the West Virginia University Medical Center in Morgantown on Tuesday, October 6.

The postgraduate course is sponsored by the TB and Health Asociation and the West Virginia University School of Medicine.

The TB and Health Association's annual business luncheon will be held on Wednesday afternoon, October 7, at the Stonewall Jackson Hotel.

Dr. William L. Cooke of Charleston, who was installed as President of the National Tuberculosis Association at the 60th Annual Meeting in New York City earlier this year, will be the guest speaker at the banquet on Wednesday evening.

Doctor Cooke, an Associate Editor of *The West Virginia Medical Journal*, was named president elect of the NTA at the 1963 meeting which was held in Denver, Colorado. He is the first West Virginian to head the 50,000-member organization.

Mr. James G. Stone, Executive Secretary of the NTA, also will appear on the program for the two-day meeting.

Ob. & Gyn. Examinations

The American Board of Obstetrics and Gynecology has announced that Part 1 examinations (written) will be held in various cities in the United States and Canada, and military bases outside the continental United States on Friday, December 11, 1964. Eligible candidates will be notified on or about November 1 where to appear for the examination.

Further information may be obtained by writing to Dr. Clyde L. Randall, Secretary, American Board of Obstetrics and Gynecology, 100 Meadow Road, Buffalo, New York 14216.

Medical Center Vice President Serves As Consultant

Kenneth E. Penrod, Ph. D., Vice President of West Virginia University in charge of the Medical Center, served during the month of August as a consultant in Latin America on ways and means for establishing new medical schools and developing those that now exist.

Kenneth E. Penrod, Ph. D.

He was a representative of the American Association of Medical Colleges (AAMC). His travel was supported by AAMC and the Agency for International Development of the U. S. State Department.

During a portion of the trip he attended the Council of the Pan American Federation of Associations of Medical Schools, meeting at Pocos de Caldas, Brazil, about 200 miles inland from Rio de Janeiro. He also visited two medical schools in Peru and one in Paraguay.

He is a member of the AAMC's Committee on Medical Education in Developing Countries. The Latin American council is composed of all the medical schools in that part of the world, an organization modeled after the AAMC.

Two other U. S. Educators also made the trip to Brazil. They were Dr. Robert C. Berson of San Antonio, Texas, president of the AAMC, and Dr. John A. C. Cooper, editor of *The Journal of Medical Education* and a vice president of Northwestern University.

Last year Doctor Penrod spent several weeks in Brazil under the AAMC-AID program. He was a consultant to Brazil's medical schools at the University of Guanabara, Rio de Janeiro, and at the University of Brasilia in the new state capital.

American Heart Association Meeting In Atlantic City, Oct. 23-25

Six clinical sessions of primary interest to the practicing physician will be held simultaneously with regular scientific sessions and programs covering a broad range of cardiovascular research at the 37th Annual Scientific Sessions of the American Heart Association at Convention Hall in Atlantic City, October 23-25.

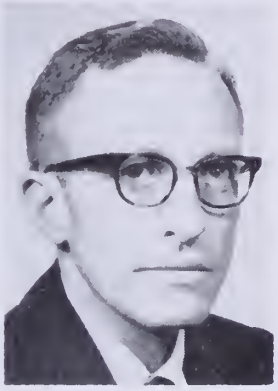
Each clinical session will include the presentation of original investigative work in addition to panels, symposia and lectures.

The annual meeting of the Association's Council on Arteriosclerosis will be held at the Hotel Shelburne in Atlantic City, October 21-22.

Registration forms, which include applications for hotel accommodations, may be obtained by writing the West Virginia Heart Association, 759 West Washington Street, Charleston, West Virginia.

Dr. H. G. Thompson, Jr., New Chairman Of WVU Department of Neurology

Dr. Hartwell G. Thompson, Jr., a former member of the faculty of the University of Wisconsin School of Medicine, has accepted appointment as Professor and Chairman of the Department of Neurology at the West Virginia University School of Medicine. He succeeds Dr. John W. Nelson.



H. G. Thompson, Jr., M. D.

Doctor Thompson, who is a native of Hartford, Connecticut, graduated from Yale University and received his M. D. degree in 1950 from the Cornell University Medical College in New York City.

He served his internship at Bellevue Hospital in New York City, 1950-51, and a residency in surgery at the Hartford Hospital in Hartford, Connecticut, 1951-52. He returned to Bellevue for a residency in medicine, 1952-54.

Doctor Thompson was assistant resident and a visiting fellow in neurology at the Neurological Institute, Columbia-Presbyterian Medical Center in New York City, 1954-57.

He joined the faculty of the Columbia University College of Physicians and Surgeons in 1957 and became Assistant Professor of Neurology at the University of Wisconsin School of Medicine in 1959. He was elevated to Associate Professor of Neurology at that institution in 1962.

Doctor Thompson was certified by the American Board of Psychiatry and Neurology in 1960 and is a member of the Wisconsin Medical Society, American Medical Association, American Academy of Neurology, American Association of University Professors and the Association of American Medical Colleges.

Cancer Society to Meet At Blackwater Falls

The annual meeting of the West Virginia Division of the American Cancer Society will be held at the Blackwater Falls Lodge near Davis in Tucker County, September 11-13. Dr. John C. Condry of Charleston, the president, will preside.

Dr. Murray M. Copeland, president elect of the American Cancer Society, will be the principal speaker at the three-day meeting. He is associate director of the M. D. Anderson Hospital and Tumor Institute in Houston, Texas, and a member of the Advisory Cancer Council of the National Cancer Institute.

Mr. William D. Gargan, nationally known entertainer before undergoing a laryngectomy, will be the speaker at luncheon meeting.

Medical Aspects of Sports Committee Advocates More Conditioning

The State Medical Association's Committee on Medical Aspects of Sports has recommended to the West Virginia Secondary Schools Activities Commission that it grant additional conditioning time for high school football players.

The recommendation was made in the committee's annual report and Dr. Richard W. Corbitt of Parkersburg, the chairman, presented the proposal during an athletic injuries program held in conjunction with the annual meeting of the West Virginia High School Coaches' Association in Parkersburg on August 7.

Officials of the coaches' association said the recommendation would be presented to the annual meeting of the West Virginia Secondary Principals next spring in the hope that it might be implemented before the start of the 1965 pre-season football practice sessions.

The committee said it believed that West Virginia high schools should be permitted to have a conditioning program for two weeks prior to the regular pre-season drills with equipment limited to football shoes and a football. The committee report stated that this conditioning program could be held, under supervision, at "either a camp or elsewhere."

It was stressed by the committee that conditioning is the most important thing in the prevention of athletic injuries and that the present two-week pre-school practice period is entirely too short.

The committee discussed this and other business at a dinner meeting held in Parkersburg prior to the athletic injuries conference.

Dr. Kenneth S. Clarke of Chicago, Coordinator for the AMA Committee on Medical Aspects of Sports, was a guest at the meeting and presented a brief resume of the AMA program. Doctor Clark was the guest speaker before the coach's group.

Dr. Charles L. Goodhand, immediate past president of the State Medical Association, second from right, attended a meeting of the Committee on Medical Aspects of Sports in Parkersburg on August 7. Speakers on a program of athletic injuries presented before the West Virginia High School Coaches' Association that night included, left to right, Mr. Blaine P. Dowler of Charleston, Dr. Kenneth S. Clarke of Chicago, and Dr. Richard W. Corbitt of Parkersburg.

In addition to Doctor Corbitt, committee members attending the meeting at the Chancellor Hotel were Drs. R. L. Chamberlain of Buckhannon; William E. Gilmore of Parkersburg; Henry R. Glass, Jr., of Charleston; Gregory B. Krivchenia of Wheeling; George Naymick of Weirton; W. H. Rardin of Beckley; and Harlan A. Stiles of Huntington.

Also attending the meeting were Dr. Charles L. Goodhand of Parkersburg, immediate past president of the West Virginia State Medical Association; Mr. Blaine P. Dowler of Charleston, Supervisor of Physical Education, Health and Safety for the State Department of Education; and Mr. Jerry Gould of Charleston, Executive Assistant of the State Medical Association.

The State Medical Association's Committee on Medical Aspects of Sports met at the Chancellor Hotel in Parkersburg on August 7. Those attending were, seated, left to right: Drs. Charles L. Goodhand of Parkersburg; W. H. Rardin, Beckley; Henry R. Glass, Jr., Charleston; R. L. Chamberlain, Buckhannon; and Kenneth S. Clarke, Chicago. Standing: Drs. Gregory B. Krivchenia, Wheeling, and William E. Gilmore, Parkersburg; Mr. Blaine P. Dowler, Charleston; and Drs. Harlan A. Stiles, Huntington, George Naymick, Weirton, and Richard W. Corbitt, Parkersburg.

Dr. Richard V. Lynch, Jr., to Preside At Diabetes Assn. Meeting

Dr. Richard V. Lynch, Jr., of Clarksburg, the president, will preside at the annual meeting of the West Virginia Diabetes Association at the UpTowner Inn in Huntington on Saturday, September 5. Doctor Lynch has extended a cordial invitation to all physicians practicing in West Virginia to attend the one-day meeting.

Richard V. Lynch, Jr., M. D.

Doctor Lynch was named president of the organization at its 1963 meeting in Charleston. He succeeded Dr. Thomas H. McGavack of Martinsburg.

Other officers named at the 1963 meeting which drew the largest number of physicians in the association's history were as follows:

Dr. Lyle D. Vincent of Parkersburg, president elect; Dr. J. Keith Pickens of Clarksburg, vice president; and Dr. Leo H. T. Bernstein of Martinsburg, secretary-treasurer.

Medical Meetings, 1964

The following is a partial list of national, state and district medical meetings scheduled for 1964:

Sept. 4—W. Va. Heart Assn., Huntington.
Sept. 10—Cabell County Symposium, Huntington.
Oct. 1—Rural Health Conf., Jackson's Mill.
Oct. 11-15—ACCP Congress, Mexico City.
Oct. 23-25—Potomac-Shenandoah Valley PG Institute, Martinsburg.
Oct. 23-25—American Heart Assn., Atlantic City.
Nov. 9-12—Interstate PG Assn., Pittsburgh.
Nov. 16-19—Southern Medical, Memphis, Tenn.
Nov. 29-Dec. 2—AMA Clinical Meeting, Miami Beach.

Symposium on Nutrition, Heart Disease

A symposium on "Modern Concepts of Nutrition and Heart Disease" will be held at the Mound Park Hospital in St. Petersburg, Florida, October 22-24.

The program has been approved for 18 hours credit by the American Academy of General Practice. Further information may be obtained by writing the Mound Park Hospital Foundation, Inc., 701 Sixth Street South, St. Petersburg, Florida 33701.

PG Course in Anesthesiology

A postgraduate course on "Advances in Anesthesiology" will be presented by the Cleveland Clinic Educational Foundation in Cleveland, September 17-18.

The registration fee is $30 and further information may be obtained by writing Dr. Walter J. Zeiter, Director of Education, The Cleveland Clinic Educational Foundation, 2020 E. 93rd Street, Cleveland, Ohio 44106.

Dr. Ralph W. Ryan of Morgantown Speaker at NMA Meeting

Dr. Ralph W. Ryan of Morgantown was among the speakers at the 69th Annual Meeting of the National Medical Association which was held at the Statler Hotel in Washington, D. C., August 2-6.

Ralph W. Ryan, M. D.

Doctor Ryan presented a paper on "Chemical Eye Hazards in Industry; Prevention Measures; and Management of Chemical Eye Injuries" before the Association's Section on Ophthalmology.

He presented a second paper at a general session on "Medical Eye Care in Industry" and also participated in a a panel discussion of new developments in the field of eye care.

Doctor Ryan has served as a member of the State Medical Association's Committee on Conservation of Vision and Hearing.

Drs. Bittinger and Newman Reappointed to MLB

Drs. W. P. Bittinger of Summerlee and Ross E. Newman of Mullens have been reappointed by Gov. W. W. Barron as members of the Medical Licensing Board of West Virginia for terms ending June 30, 1969.

Doctor Bittinger, who received his M. D. degree from the Medical College of Virginia, has served as a member of the Medical Licensing Board since 1949.

Doctor Newman was named to the Board last February to fill the unexpired term of the late Dr. Doff D. Daniel of Beckley. He received his M. D. degree from the Louisiana State University School of Medicine.

Other physician members of the Medical Licensing Board are Drs. George F. Evans of Clarksburg, the chairman; Frank J. Holroyd, Princeton; D. E. Greeneltch, Wheeling; Everett H. Starcher, Logan; and N. H. Dyer, Charleston, Secretary.

Dr. C. R. Kessel, Mrs. G. T Evans Named to Commission on Aging

Gov. W. W. Barron has named a Ripley physician and the wife of a Fairmont physician to the State Commission on Aging.

Dr. C. R. Kessel of Ripley and Mrs. G. Thomas Evans of Fairmont were among those receiving the oath of office from Secretary of State Joe F. Burdett on August 6.

The new commission was authorized by the West Virginia Legislature earlier this year to replace an advisory committee which had been established by an executive order.

New Association Members

Dr. David A. Belton, 431 South Fayette Street, Beckley (Raleigh). Doctor Belton was born in Palatka, Florida, and was graduated from Lincoln University. He received his M. D. degree in 1926 from the Howard University College of Medicine. He served an internship at Freedmen's Hospital in Washington, D. C., 1926-27, and was licensed to practice medicine in West Virginia in 1927. He is engaged in general practice.

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Dr. Donald R. Bernhardt, 3404 Packard Drive, Parkersburg (Parkersburg Academy). Doctor Bernhardt, a native of Baltimore, was graduated from Columbia College and received his M. D. degree in 1945 from the New York University College of Medicine. He interned at the Brooklyn Hospital, 1945-46, and served a residency at Baylor University Hospital, 1948-51. He served as a Captain in the Medical Corps of the U. S. Army and was previously located in Dallas, Texas. His specialty is radiology.

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Dr. Harold P. Dinsmore, 1323 Quarrier Street, Charleston (Kanawha). Doctor Dinsmore, a native of Wilmington, Delaware, attended the two-year WVU School of Medicine and received his M. D. degree in 1958 from the Medical College of Virginia. He interned and served a residency at Charleston Memorial Hospital, 1958-63, and his specialty is general and vascular surgery.

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Dr. Daniel Hamaty, Charleston Memorial Hospital, Charleston (Kanawha). Doctor Hamaty was born in Houtzdale, Pennsylvania, and received his M. D. degree in 1953 from Hahnemann Medical College. He interned and served a residency at Fitzsimons Army Hospital in Denver, 1953-58, and served as a Captain in the Medical Corps of the U. S. Army. He served as an instructor in medicine at Hahnemann Medical College, 1961-63, and was formerly located in Reading, Pennsylvania. His specialty is internal medicine.

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Dr. G. J. Pentecost, Jr., The Wheeling Clinic, Wheeling (Ohio). Doctor Pentecost, a native of Scranton, Pennsylvania, was graduated from Drew University and received his M. D. degree in 1955 from the Temple University School of Medicine. He interned and served a residency at Temple University Hospital. He served as a Captain in the Medical Corps of the U. S. Air Force, 1957-59, and his specialty is ophthalmology.

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Dr. Ruth M. Phillips, WVU Medical Center, Morgantown (Monongalia). Doctor Phillips, a native of Johannesburg, South Africa, was graduated from Mt. Holyoke College and received her M. D. degree in 1948 from the Johns Hopkins University School of Medicine. She interned at Vancouver General Hospital in Canada, 1948-49, and served a residency at the Johns Hopkins Hospital, 1949-52. She also had postgraduate work at the Childrens Medical Center in Boston and previously served as instructor in pediatrics at the Boston University School of Medicine. She is currently serving as Assistant Professor of Pediatrics at the WVU School of Medicine.

Dr. Hilton Rocha, Hopemont Sanitarium, Hopemont (Preston). Doctor Rocha was born in Brazil and received his M. D. degree from the Faculdade Fluminense de Medicina. He interned at St. Joseph's Hospital in Lowell, Massachusetts, and served residencies at Tewksbury State Hospital in Massachusetts and at Hopemont Sanitarium, 1955-63. He was licensed to practice medicine in West Virginia in 1963.

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Dr. Mary S. Skinner, 905 Maple Road, Charleston (Kanawha). Doctor Skinner, a native of Slidell, Louisiana, was graduated from Louisiana State University and received her M. D. degree in 1955 from the Louisiana State University School of Medicine. She interned and served a residency at Charity Hospital in New Orleans, 1955-58. She previously was located in New Iberia, Louisiana, and her specialty is pediatrics.

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Dr. Margaret I. Stemple, 225 Monongahela Building, Morgantown (Monongalia). Doctor Stemple, a native of Morgantown, was graduated from West Virginia University and received her M. D. degree in 1940 from Rush Medical College. She interned at Loretto Hospital in Chicago, 1940-41, and served a residency at University Hospital in Little Rock, Arkansas, 1941-42. She previously was located in Chicago and is now engaged in general practice.

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Dr. Clifford A. Stevenson, Beckley Memorial Hospital, Beckley (Raleigh). Doctor Stevenson, a native of Findlay, Ohio, received his M. D. degree in 1936 from the Emory University School of Medicine. He interned at Maryland General Hospital in Baltimore, 1936-37, and served residencies in Arizona and Colorado. He also served residencies at the U. S. Naval Hospital in San Diego, 1948-49, and at Children's Orthopedic Hospital in North Carolina. He served with the Medical Corps of the U. S. Navy, 1939-63, and was retired with the rank of Captain. His specialty is orthopedic surgery.

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Dr. Janet H. Strader, 198 Spruce Street, Morgantown (Monongalia). Doctor Strader was born in Harman, West Virginia, and was graduated from Davis-Elkins College. She attended the two-year WVU School of Medicine and received her M. D. degree in 1960 from the Medical College of Virginia. She interned at Charleston Memorial Hospital, 1960-61, and is engaged in general practice.

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Dr. William A. Welton, WVU Medical Center, Morgantown (Monongalia). Doctor Welton, a native of Fairmont, was graduated from Harvard College and received his M. D. degree in 1954 from the University of Maryland School of Medicine. He interned at Meadowbrook Hospital, 1954-55, and served a residency at the Roosevelt Columbia-Presbyterian Hospital in New York City, 1955-57. He served as a Lieutenant in the Medical Corps of the U. S. Navy and had postgraduate work at the Armed Forces Institute of Pathology. He currently is serving as Assistant Professor of Medicine and Chairman of the Department of Dermatology at the WVU School of Medicine.

The West Virginia Medical Journal

October, 1964 Vol. 60, No. 10

Medical Progress, Its Problems and Challenge*

Charles L. Goodhand, M. D.

As your President, this past year has proven to be one of hard work, much satisfaction, and has revealed several of the basic problems of medicine, as well as its many accomplishments. It is, therefore, with sincere pride and humility that I stand before you as the President of the West Virginia State Medical Association —one of the fifty main units of organized medicine in this great Nation of ours—representing a great profession with a glorious past, a truly marvelous present, and a future both challenging and unlimited. A profession that has contributed tremendously to the advancement of medical science, and to the betterment of the public health.

The medical profession and all organized medicine is dedicated to the care of the sick, the prevention of disease processes, both organic and functional, and the promotion of both medical research and clinical investigation. In addition to the aforementioned primary functions, organized medicine has the added obligation of protecting the general public as well as the profession from all extraneous influences and pressures interfering with or subverting the primary functions of the physician.

The Lines of Medical Communication

Throughout the years, in our free system of medicine, time has proved the value of our method of communication, both in the teaching of medical students and in the practice of medicine. The teamwork that has existed between the men in research in the several scientific disciplines, the teachers, and the practicing physicians has evolved medical science to its present high status. This necessarily demonstrates that these essential elements toward medical progress must function in concert to maintain the goal of excellence. However, in most strong Foundations, even such as this, a few weak spots can be found upon close inspection.

I should desire to stress at this point the need for organized medicine to strengthen its system of continuing medical education beyond the years of formal training of the physician. This is necessary to assure that patients, and society in general, will reap the full benefits of rapidly expanding medical scientific knowledge. The need is also present for increasing the number of new physicians to enter the private practice of medicine, especially in the field of general practice. This void is becoming constantly more apparent. Our system of medical education must encourage and also find a more suitable method for the training of physicians entering general practice, as well as the specialties.

Results of the American Free System of Medicine

For the first time in our history the average life expectancy for Americans now stands at 70.2 years.

Four and one-half million Americans are alive today who would be dead if the mortality rate of 25 years ago still prevailed.

Eighty per cent of the drugs commonly prescribed today were unknown just 15 years ago.

The Author

- **Charles L. Goodhand, M. D., Parkersburg, W. Va., Immediate Past President of the West Virginia State Medical Association.**

*Annual Address by the President, West Virginia State Medical Association, 97th Annual Meeting, The Greenbrier, White Sulphur Springs, August 22, 1964.

The United States has made more important drug discoveries in the past two decades than all the rest of the world combined, or seven times as many as the next leading country.

Significant break-throughs have been accomplished in the treatment of infections that formerly had high mortality rates.

Most of the infectious diseases that formerly reached epidemic proportions are now well controlled and prevented by the use of vaccines, and other specific drugs.

Maternal mortality rates have now reached the lowest levels in our history due to patient education, prenatal care, control of infection, more satisfactory control of pregnancy toxemias and improved methods of combating hemorrhage and shock. However, I might add there is still apparent need for greater improvement.

Perinatal fetal mortality and morbidity rates are now lower than previously, but there is room for much improvement. A concentrated effort is being directed toward this problem, which includes the Perinatal Fetal Mortality and Morbidity Committee of the West Virginia State Medical Association, established during the past year.

Surgical progress has been truly remarkable in recent years, due primarily to the development of new surgical techniques in dealing with open heart surgery, chest surgery, vascular surgery, and all other surgical branches. Playing an important part in surgical advances are the remarkable developments in internal medicine and anesthesiology.

Many noteworthy advances have been made in pediatrics, thereby saving innumerable lives. Several advances of great importance are: the control of infections, the exchange transfusions in congenital hemolytic disease of the newborn, and the surgical treatment of many congenital defects that formerly resulted frequently in mortalities.

These advances that I have briefly mentioned represent only a segment of medical progress relating to disease processes.

Some of the Factors Involved in Medical Progress

(1) There is now a record number of hospital beds in this country—1,670,000, an increase of more than a quarter million beds since 1948.

(2) Medical science has permitted the average length of stay of a patient in a general hospital now to be at the lowest point in history.

(3) During the past 13 years, this nation has built 763 new hospitals—far more than any other nation in the world, increasing our total number of hospitals to about 7,000.

Areas of Improvement and Change

The evolution of our present industrialized society has had a profound effect on both medical education and medical practice. The past few decades have seen more rapid and revolutionary changes in the branches of the scientific world, including medical science, than in any other era. This research and resultant development have had tremendous impact on the intellectual, industrial and productive life of our country. It has, in fact, created problems in human relations, education and democratic government. An adequate solution of these problems will require wisdom, unselfish leadership, and much faith in man's integrity.

As we know, the rapid advance of medical science during this decade is largely an accumulation of the knowledge of all the scientific disciplines.

Simultaneously with the scientific development there arises a necessity for increased responsibility of the individual physician to thoroughly utilize this vast fund of knowledge in the prevention, diagnosis and treatment of disease processes. The educational process of the modern physician, as a part of the ultimate goal of excellence, has increased in complexity and has tended toward increased specialization. As our core of knowledge grows still larger we can expect even more specialization. This gives birth to certain inherent dangers of forgetting man as a whole and as an individual. We must be on guard.

The ultimate beneficiaries of medical education are the recipients of medical care, the individual patients. It is therefore essential that the close relationship between doctor and patient be encouraged and maintained to secure the maximum benefit for both. There is no place in modern society for assembly line medical practice, or for the interjection of any foreign influence between doctor and patient. Medical practice is still both an art and a science, and its success is assured as long as mutual understanding exists between the public and the profession.

The practice of medicine today has evolved into four basic stages as a result of accumulated medical knowledge, life expectancy, and population trends. I shall briefly outline these stages as they have great importance in medical practice of both the present and the future.

Stage One—The Foundation of Disease

This stage initiates before birth and includes the genetic heritage of the individual. It is the time in which the foundation for later illness is established, the stage in which the aggregate of

a large group of factors determine a person's specific pattern of health and disease. Here, also, an alteration in these patterns is capable of checking or preventing the development of disease. Medical practice as yet has had very little activity in this field.

Stage Two—Pre-Clinical Disease

This is the stage when a health problem is developing, but is not acute enough to make the victim aware, such as—precancerous lesions, prediabetic conditions. Detection is now all important in finding emerging problems before they fully develop into disease. Currently, this stage is receiving closer attention than previously, as diagnostic methods are being developed.

Stage Three—The Treatment of Symptomatic Disease

This stage represents the predominance of clinical medicine, and it is to this stage that medicine has devoted the most thought. It is the type medicine the public is most aware of, and to which most of the medical care system is devoted. Generally, physicians consider it their major responsibility because of its familiarity. In fact, medical training is geared, in large, toward this stage of medicine.

Stage Four—Rehabilitation and Management of Medical Conditions for Which Biologic Cure Is Not Possible

This is the stage for control of disability through rehabilitation, and of aid to the patient in self-reliance. It deals with handicapping conditions that, if not attended to, usually compels dependence upon others. This includes older persons with chronic disease, and as life expectancy and thus, our aging population increases, rehabilitation assumes ever greater importance.

The tremendous scope of present and future medical practice requires the coordination and unity in purpose of medical educators, teachers, and the complete spectrum of medical practitioners in order to properly guide, *in unison*, the medicine of tomorrow. There should be no shortage of physicians in any category if the complete picture of medicine is presented to our medical students, and to those already members of the profession.

Problems in West Virginia

The State Medical Association has dealt with several problems of importance during the past year that I shall mention briefly.

(1) The 1964 Legislature passed a prepaid, voluntary, non-profit, health care bill that is now law. This bill contained the safe-guards advocated by the State Medical Association. We may expect attempts to amend this bill by certain special interest groups at future sessions of the Legislature.

(2) Attempts to amend the State Medical Practice Law will probably be made as in the past. Certain changes are needed, but these must be carefully controlled by the State Medical Association and allied health groups.

(3) The changes in the State commitment laws for the mentally incompetent, as presented to the Legislature by the State Medical Association and the State Department of Mental Health, have not as yet been acted upon by the Legislature. This is extremely important legislation and demands action at the next session of the Legislature.

(4) The Medical Examiner's bill was passed two years ago, but the necessary funds to implement the law have not been appropriated.

(5) The Medical Economics and Joint Conference Committees have made considerable progress in solving some of the problems relative to the General Welfare Medical Program and Medical Aid to the Aged Program. Thus, numerous conferences with the State Welfare Commissioner are proving to be constructive and fruitful. There are still many facets of the numerous welfare medical programs that are not conducive to good medical practice; therefore, constant attempts must be made to improve this situation.

(6) The Mental Health Planning Program that is now being conducted throughout the State deserves the serious consideration of every member of the medical profession. Each physician should personally share in this program. It represents an attempt to improve the psychiatric facilities at the local community level, a need of which we are all aware.

(7) The evaluation of complete physical disability, Aid to Dependent Children (ADC) cases in Kanawha County, as a special project of the Kanawha County Medical Society during the past two years, will be extended into other counties during the next year. The implementation of this project by members of the Kanawha Medical Society deserves commendation from this Association, as well as all citizens of the State.

The National Scene

The medical legislative picture on the national level is somewhat confused at the present time. The King-Anderson Bill was not reported out of the House Ways and Means Committee. However, a bill was issued recommending an increase

in Social Security benefits, an increase in the Social Security tax rate, a broadening of the tax base from $4,800 to $5,400, and the inclusion of all self-employed physicians under the Social Security System. This bill was passed by the House of Representatives and sent to the Senate. The Senate Finance Committee earlier this week voted to delete the sections which would place physicians under Social Security and also refused to add the King-Anderson bill as a "rider;" however, there is a good possibility that efforts will be made to amend the bill on the floor when the Senate reconvenes following the Democratic National Convention.

The ultimate effect of the "Anti-Poverty," and the "Appalachian Project" measures upon the private practice of medicine are as yet unknown. This will depend entirely upon the scope of this legislation in regard to medical matters, in particular the control of the care and treatment of patients by government authority.

Conclusion

As a result of the activities of your President during the past year there are several issues and trends that have become quite obvious. I shall briefly discuss several of these for your consideration.

The West Virginia University School of Medicine is increasingly assuming its important role of leadership in medical education in this State. Its influence is likewise having a constructive impact on medical practice. My relationship with various members of the faculty of the School of Medicine during the past year has been most pleasant and helpful, and the spirit of cooperation and interest in the activities of the State Medical Association has been distinctly demonstrated. Teamwork of this nature between the physicians of the State and the School of Medicine will be of great benefit to medicine.

In meeting the challenge of modern medicine, and the demands and needs of the public in the entire health field, it is imperative that methods for continuing medical education be implemented throughout the State and Nation. The American Medical Association already has such a program in effect. There is a joint responsibility present in this State for the encouragement and implementation of such a program. The responsibility is shared by the State Medical Association and its Committee on Medical Education and Hospitals, the West Virginia University School of Medicine, the teaching staff of its hospital, county medical societies, community hospitals, and the individual physicians. It has been gratifying to discover a cooperative spirit present on the part of each of these groups for the realization of such a program.

There is a definite need in the State for closer communication and relationship between the county medical societies, the various specialty groups, the Academy of General Practice, the State Medical Association and the American Medical Association. This was emphasized very clearly recently by both Doctor Annis and Doctor Welch speaking in relation to the national picture. May I appeal to you for a united rejuvenation of purpose and effort since we are already aware of certain dissipating forces existing both internally and externally to the profession that could and will fragmentate our strength if not checked. As a result of this unity, there would be a greater understanding of existing problems, and an encompassing participation in programs of necessity and mutual desire.

We read and are told repeatedly by certain members of the communications media, by members of other professions and vocations, and by a few members of our profession, that organized medicine takes the negative approach most frequently in its attitudes toward the numerous problems that face medicine, especially in the fields of medical economics, legislation and public relations. We are further told that our ideas of "progress" and "social consciousness" are remiss. May I refer our critics to the lessons of history through the ages, and the basic ideals upon which this republic was founded. We live in a society still essentially free, one that gives to each individual the right of choice. Throughout the history of mankind such a society has *not* been the general rule, but the exception. Thus far it has been proven successful *in this Nation.*

The medical profession does have a positive approach to matters that concern it. May I enumerate a few of the most important precepts and opinions which we advocate:

(1) We *believe* in the dignity and freedom of the individual as expressed in "The Bill of Rights."

(2) We are *dedicated* to the care and treatment of the sick and to the prevention of disease processes.

(3) We are *for* the free practice of medicine, and the free enterprise system.

(4) We are *for* the medical and hospital care of the truly indigent patients who need this care. This is demonstrated daily in physicians' offices, clinics, hospitals and private homes throughout the Nation.

(5) We are *for* financial help to those truly indigent patients who have become public charges; utilizing the family, local and state units in that order, and with proper safeguards against exploitation.

(6) We are *for* help to any medically indigent older citizen who needs help, in a manner that maintains his personal dignity, freedom of choice and freedom from compulsion.

(7) We are *for* pre-paid and voluntary medical insurance plans that comply with State insurance laws, protect the policy-holders, have boards of directors that represent the public, the hospital and medical professions, and that do not represent a promotion by any self-interested segment of the population, or the interposition of a third party between the patient and the physician.

We also take justified pride in being opposed to those ideas that are not in the interest of the public, our patients, or the practice of medicine. It is well to remember that American Medicine has become great as a result of dedication, free competitive spirit, and the pursuit of the goal of excellence.

A source of solace to any physician concerned and depressed by medicine's problems are the following words of "Descartes":

> "*If ever the human race is raised to its highest practical level, intellectually, morally and physically, the profession of medicine will perform that service.*"

Positive Action on Negative Results

In fields which do not involve national security, such as in medical research, every recipient of a grant or contract of any kind from the Federal Government should, in our opinion, be required to submit a complete, detailed report at periodic intervals on what he did with the government funds. We believe a complete yearly report would be adequate, provided the report was in the form of a detailed paper which would provide enough information so that other scientists would know exactly what has been done and what the results were. These reports should then be properly indexed by the government and made available to any interested party. This is the only way the scientific community can be kept currently informed of research progress.

Another advantage of having these scientific reports, properly indexed, is that unsuccessful experiments or so-called negative results would then be available. This is not the case at present since most scientific journals hesitate to publish results of unsuccessful experiments. As a result many scientists go over the same ground again, not realizing that predecessors have already been unsuccessful.—Austin Smith, M. D., President, Pharmaceutical Manufacturers Association, in letter to Honorable Carl Elliott, Chairman, House of Representatives' Select Committee on Government Research, December 20, 1963.

Chronic Bronchitis*

Leslie N. Gay, M. D.

In spite of the advances in the treatment of bronchopulmonary infections, chronic infections of the bronchi are increasing in importance. The term, "chronic, suppurative bronchitis," refers to any chronic, inflammatory bronchial disease with significant purulent sputum, in which such specific conditions as tuberculosis, mycotic infection, lung abscess and neoplasm have been excluded.

Control of chronic infections of the bronchi is difficult because of the structural and functional abnormalities that predispose to infection. In order to be successful in therapy, adequate drainage of the bronchi is essential and, therefore, antibacterial therapy must be used in conjunction with other measures if maximal benefit is to be achieved. Identification of pathogenic bacteria may be impossible but unless infection is controlled, edema and congestion persist. To understand the manifestations of bronchitis and pulmonary emphysema, one must have knowledge of the anatomic structure and physiologic properties of the lungs.

Anatomy

The lungs may be considered as consisting of two parts:

(1) Trachea, bronchi and bronchioles. This system of tubes conducts the air to the terminal air spaces. The walls of the bronchi are lined with ciliated epithelium and contain numerous mucous glands. The mucus acts as a protective coating but if excessive in amount can readily obstruct the flow of air. Resistance to the movement occurs.

(2) Terminal air spaces include the bronchioles, alveolar ducts, atria and alveoli. Most of the air in the lungs is contained within these structures. Because of the small size an enormous surface area is available for diffusion of gases between the alveoli and the pulmonary capillary bed. In man the surface area has been estimated to be 25 square meters.

The elastic property of the lungs is intimately related to the terminal air spaces; also, it is dependent on the size of the air spaces and is altered significantly when the air spaces are enlarged, as in emphysema.

When the structures are normal in dimension, movement of air into and out of the lungs is normal. Air cannot be forced from the lungs by any external compression. The bronchioles and small bronchi, however, will collapse if subjected to external pressure.

Effect of Bronchitis and Pulmonary Emphysema On Pulmonary Function

Keeping in mind these remarks, impairment of pulmonary function associated with chronic bronchitis and pulmonary emphysema can be readily explained.

Enlargement of the terminal air spaces alters the elasticity of the lungs and when the lungs empty inadequately, residual volume increases and vital capacity diminishes.

The pathological process is localized rather than diffused; some areas of the lungs are ventilated better than others and air is distributed unequally in various parts of the lung. The surface area thus is diminished and diffusion is more difficult if the normal alveoli are replaced by large air spaces. Thus, bronchitis and emphysema serve to alter the function of the lungs.

Pathology

The pathogenesis of bronchitis and emphysema has been especially studied by the British workers. In addition to inflammatory changes in the walls of the bronchi and bronchioles, hypertrophy of the mucous glands and goblet cells often is observed. Thus, there is excessive production of mucoid sputum due to these changes.

In pulmonary emphysema, the pathologic picture is extremely varied. In the advanced stage of the disease, normal structures of portions of the lungs may be completely replaced by large air spaces of various size containing strands of tissue that represent remnants of the normal lung

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and blood vessels. In this same lung there may be areas of normal-appearing lung tissue which undoubtedly sustain life unless over-exertion is practiced. In many elderly patients, enlargement of the normal air spaces is seen and emphysematous bullae may be found at autopsy in the lungs of these persons who did not have respiratory symptoms during life.

Epidemiologic Studies

The exact cause of bronchitis and emphysema is unknown, but epidemiologic studies carried out in Great Britain have cast considerable light on the origin of the diseases. British writers tend to use the term, "chronic bronchitis," to encompass the whole syndrome whereas Americans place more emphasis on pulmonary emphysema. Chronic bronchitis is very common in Great Britain and is one of the major causes of death, less so in the United States. Epidemiologic studies here and abroad have shown clearly that environmental factors are important in its development. Death from this cause is more frequent among unskilled laborers than among office workers. The disease is higher in mortality among residents of large cities than among persons in country areas. Atmospheric pollution and cigarette smoking play important roles. The disease is much more common in men than in women and affects chiefly persons in the older age group. Thus, in diagnosis, the history, long-standing chronic cough and insidious onset of exertional dyspnea to the point of incapacity, is of great value. Attacks of bronchitis (acute) aggravate the symptoms which may be asthmatic in character. X-ray studies of the chest are of less value in diagnosis than the history. Unless large bullae are present, the lesions are not visible radiographically although x-ray is essential to rule out more serious diseases, especially left ventricular failure and pulmonary fibrosis.

Bacteriology of Chronic Bronchial Infections

The normal bronchial tree is free of bacteria. In chronic bronchitis there is invasion of the bronchial tree by common mouth flora. The most frequently isolated bacteria other than mouth flora in untreated bronchitis are Hemophilus influenzae and Diplococcus pneumoniae, Staphylococcus aureus and, less frequently, Streptococcus haemolyticus. Pseudomonas aeruginosa and Proteus are occasionally responsible.

Viral Studies in Chronic Bronchitis

Exacerbations of chronic bronchitis, defined as an increase in cough and in volume and purulence of the sputum without evidence of pneumonia or bronchopneumonia, often are preceded by symptoms of an acute upper respiratory tract infection. Exacerbations of chronic bronchitis, often severe but without x-ray changes, are encountered in association with proved infection by the virus of Asian influenza. Jack and Gandevia reveal the results of virus studies using cultural and serological methods in a series of patients with chronic bronchitis observed over a one-year period (1958).

Nineteen patients, (14 males, 5 females), were studied and followed carefully throughout the year. All patients had a persistent cough, with sputum which at least for some part of the year's observation was purulent or mucopurulent. In all patients bacterial pathogens or potential pathogens were isolated from the sputum in one or more cultures, the chief pathogen being H. influenza. The virus studies were continued for 12 months. Four of the patients died during the winter but no autopsy material was obtained for viral study. Numerous attempts at virus isolation failed in all patients. Serological findings may be summarized by saying that no change in levels of antibody to influenza A or B was observed in any of the patients with significant antibody titers. Jack and Gandevia also studied numerous cases of presumed viral infection of the pulmonary tract at the city morgue in Melbourne, Australia, during the winter months. They failed to isolate a virus from any of the autopsy specimens. Thus, it is assumed that bacterial infection was the immediate cause of death although a virus may have been the primary cause of illness.

Mortality and Morbidity

Mortality and morbidity statistics suggest that miners and foundry workers are more prone to bronchitis than are other industrial workers. The question arises as to whether occupation plays a role. An investigation by Higgins, Cochrane and Gilson was designed to compare the prevalence of bronchitis and respiratory disability in a representative group of miners, foundry workers and other industrial workers living in a small (18,000 inhabitant) city in Wales. Seven hundred seventy-six men were used, divided by age into two groups: ages 25 to 34 and 55 to 64; and by occupation into 4 groups: non-dusty, miners and ex-miners, foundry and ex-foundry workers, and other dusty jobs. Respiratory symptoms were recorded on a questionnaire. The ventilatory capacity was assessed by means of the forced expiratory volume and recorded as the indirect maximal breathing capacity.

Miners and ex-miners recorded a higher prevalence of respiratory infections and a lower maximal breathing capacity than men who worked

in the dust-free operations. In the older age groups, the differences were not significantly great but in the younger men they were quite significant. The number of years spent on coal mining shifts was used to assess the importance of exposure to coal dust. In the elderly miners without pneumoconiosis, there was a significant increase in the prevalence of breathlessness, accompanied by a fall in the mean breathing capacity with increasing years spent in the coal mining industry.

In both age groups, the prevalence of respiratory infection was lower and the mean breathing capacity was higher in non-smokers than in smokers. Heavy smokers recorded a higher prevalence of symptoms than light smokers. To determine environmental association, the wives of the men were studied and the findings suggested that the wives of the men who worked in dusty jobs had a somewhat higher prevalence of cough and chest illnesses during a period of three years than those of the men who worked only in dust-free occupations.

Indications for Antibacterial Therapy

Chronic bronchial infection may occur without the systemic manifestations such as fever and leukocytosis. Even so, antibacterial drugs may be necessary, and grossly purulent sputum is an indication that infection is present. Eosinophils in large numbers may or may not be present. In the case of an allergic manifestation eosinophils are encountered. The American Thoracic Society (Committee on Therapy) recommends penicillin, especially if H. influenza is encountered. Because of the danger, however, of penicillin reaction, which is unpredictable, penicillin should be avoided and instead Tetracycline is preferred. Chloramphenicol might be used but because of the hematopoietic toxicity caution is necessary. If Staphylococcus is the principal pathogen, susceptibility tests will be the answer as to which antibiotic is the most effective. Erythrocin is a most helpful agent.

Continuous or Prophylactic Therapy

Even with the best results from the intensive treatment of chronic bronchial infections, recurrence of infection is usual. Continuous effort to promote drainage undoubtedly helps to delay the return of infection but all to often the period of freedom from infection is short lived. Tetracycline has been used to prevent exacerbations. Most patients tolerate prolonged or repeated use of the tetracyclines in small doses and infections by resistant bacteria and fungi usually do not develop. It would seem logical therefore, that any long-term use of antimicrobials would be more effective if initiated when the patient has been made as free from infection as possible by the intensive therapy.

Supplementary Therapeutic Measures

The greatest contribution to the control of chronic broncitis is elimination of atmospheric pollution and institution of effective measures against cigarette smoking. These accomplishments alone would bring about a major reduction in the incidence of the disease.

Atmospheric pollution by toxic products of combustion such as the automobile gases and the fumes associated with industry and large. poorly constructed incinerators undoubtedly plays a role, and freeing the air of these products would reduce prevalence of the disease.

Unfortunately, untreated chronic bronchitis is complicated by asthmatic respiration which, at times, is equally as severe as the attacks of allergic bronchial asthma. Should this group of symptoms appear, then, in conjunction with antibiotics and bronchodilators, steroid therapy is indicated and is of the greatest help. Five or 10 mg. of reliable Prednisone two or three times daily should be prescribed until the symptoms are under control. On occasion more rapid effect is obtained by a daily dose of 80 units of ACTH given intramuscularly for three doses. I have encountered no side reactions from these brief courses of steroid therapy and have rapidly terminated prolonged distress and chronic illness in many patients by placing them on this regimen.

It should be mentioned that vaccine therapy has been administered to many patients subject to recurring bronchial infections. Ritchie showed in his report of 1958 a significant reduction of colds in an adult population given prophylactic autogenous vaccine containing all flora grown from the individual's bronchial secretion. I have had similar experience. I must warn, however, that when trials of bacterial vaccine have been conducted in a properly controlled manner, no conclusive benefit has so far been shown to follow the administration of this biological product.

In conclusion, therefore, chronic bronchitis is a frequently encountered disease of the bronchial tract. A careful history and clinical examination are essential to rule out the more acute and serious diseases of the lung. Routine respiratory function tests are of doubtful value but radiological examination should be a routine

procedure, as should a careful nasopharyngoscopic examination. There is general agreement that atmospheric pollution and smoking, particularly cigarette smoking, are major etiological factors. Bacterial infection aggravated by urban crowding and overheating plays an important role in the cause and progression of the disease. Therapy, including the use of drugs, should be tailored to individual requirements and should include breathing exercises, elimination of cigarette smoking and avoidance of irritating occupational fumes.

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Manuscript Information

Manuscripts to be presented for publication in *The West Virginia Medical Journal* should be typewritten, triple-spaced, on one side only of firm (not onion skin or flimsy), standard letter sized (8½ by 11 in.) white paper. Wide margins (at least 1¼ in. on left) should be left free of typing. On the first or title page should be shown the title of the article, the name (or names) of the author, and his degrees. Pages should be numbered consecutively, the page number being shown in the right upper corner along with the surname of the author.

Authors are requested to submit a carbon copy with the original or retain same in the event the manuscript is lost in transmittal.

Illustrations should be numbered and their approximate locations shown in the text. Each should be identified by placing on its back the author's name, its number and an indication of its "top." Drawings and charts intended for cuts should be done in black (India) ink on pure white. Photographs should be on glossy paper and minimum of about 5 by 7 in. in size. A legend should be provided for each illustration and, preferably, attached to it. The author will bear the cost of all over two one-column halftone cuts.

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Special Article

Safeguarding The Health of The Athlete*

Kenneth S. Clarke, Ph. D.

THE topic, "Safeguarding the Health of the Athlete," is certainly a safe one. All coaches want healthy athletes. So do administrators. So do parents. So do communities. But so do professional gamblers who stake their periodic investments primarily on the health status of the competing athletes. Because gamblers want their team to win. So do communities. So do parents. So do administrators. So do coaches.

Therefore, this topic is not only safe, but loaded. With all due respect to a coach's natural sympathetic feelings for an injured human being, he knows that his game plans and strategies hinge directly on the availability of his athletes and of the opponents as well. Moreover, the winning-losing factor in athletics creates a potent temptation to flirt with the health and safety aspects of sportsmanship and regulations governing play This may appear to produce a conflict of interest between health and winning, but is this truly the case? The healthy athlete is the available athlete. Unhealthful practices can cause disability, thus removing the athlete from competition. Premature exposure to reinjury and other inappropriate activity can retard healing, add to the seriousness of the disability, and delay the return of the athlete to a competitive level of performance. Therefore, this speech could just as well be titled "How to Be a Consistent Winner" without changing the text at all.

The Nature of Athletics

It is readily apparent that the nature of athletics presents unique implications for health that must be understood before safeguards can be discussed.

Athletics provide special and organized attention to a select group, a community-endorsed program for those who are sufficiently motivated and capable of striving for excellence in sports. Participation is voluntary; however, compulsory dedication to the team and to maximal performance is implied.

*Presented before the 5th Annual Clinic of the West Virginia High School Coaches' Association in Parkersburg, August 7, 1964.

The Author

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The outcome of the contest is an artificial process, a result of some arbitrary rationale by a rules committee. As one pro quarterback has said, "I've never lost a ball game; time just ran out on me a few times." Being a Chicago Cub fan, it is my opinion that the Cubs would be in first place if baseball games were 6 innings instead of 9. Some of you may have similar "if's" that would increase your winning record. On quick recall, though, I can think of only one "sport" that is not necessarily terminated by some arbitrary time limit, distance, or other regulation and that is bullfighting (if that is sport). Yet where is the popular evaluation of the coach, the leader of men? At the scoreboard at a particular moment of the game when the officials say it's time to call it a day. This is the apple tree in the Sports Garden of Eden.

The nature of competitive athletics, calling for sacrifice to the cause and imposing arbitrary boundaries, removes some of the natural self-limiting safeguards found in informal sports. For example, the varsity athlete who becomes fatigued or disinterested usually cannot just quit and rest at will. The responsibility falls on the perception of the team's leadership—the coach, trainer and team physician who, while encouraging maximal effort, also must educate and protect the athletes in their charge regarding the risks involved.

This element of risk, the possible dangers inherent in leading any type of active life, has both absolute and relative implications for athletics. Coaches shudder at the many circumstances or agents that may reduce the athlete's effectiveness in the game, if not remove him completely from the competition. For a particular athletic competition, it means very little to the record of

the game whether a sidelined athlete was disabled by a broken leg, a case of hepatitis, heat exhaustion, or an infected blister.

Any discussion of athletic disability must consider also the high standards of performance imposed upon the athlete. Certainly, prevention of major injuries is a serious need; but in addition what is considered minor in the medical sense may be major to the athlete whose competitive participation is thereby limited or deferred. A sore shoulder may be judged as a severe disability to the baseball star whose pitch has lost some of its effectiveness as a result. The same sore shoulder belonging to the casual sportsman or non-athlete, however, might hardly be noticed.

In discussing the nature of athletics so far, I have spoken of risks, disability, removal of safeguards, and inherent temptations to ignore the health of the athlete. On what grounds can you justify encouraging our nation's youth to so engage in sports, especially under the auspices of an educational institution?

The answer is simple if one has faith in two assumptions. The answer is not so simple if obscured by abuses from violations of these assumptions. First, sports must be considered as part of the educational process. If not, there simply is no place for the athletic program in our schools and colleges. Therefore, sports evidently have the means to develop desirable attitudes and behavior that contribute to one's health, and health defined as the fullest utilization of one's natural resources is most appropriate. The key words "contributed to the health" are vital in this consideration. The alternative would be the evaluation of sports as to the absence of illness or injury, a far more limited and less effective approach or justification.

For example, the challenge of self-discipline imposed on the athlete to mobilize his fullest natural resources against the adversity of equally motivated opponents and within the regulations imposed on him has profound value and contributes toward the development of a desirable concept of self. In very few other situations are youth forced or allowed to demonstrate so nakedly that they are equal to such a challenge.

Secondly, no injury *has* to occur to a participant in sports. For example, football players do not automatically receive a knee injury. If knee injuries were automatic, football would have no place in our society. Some players do get knee injuries, however, and the causes must be defined and appropriate preventive measures taken to eradicate this occurrence. I used the term "eradicate" not realistically but philosophically because by extending this logic, all injuries and health hazards are theoretically completely preventable. This approach admittedly is gross optimism, and should not imply that all injuries are results of negligence, but it does underly justification of encouraging suitable sports participation.

But why sports? Why not a non-combatant form of isometrics or isotonics called exercise or calisthenics? There is nothing wrong with calisthenics if they are suitable to the individual and are practiced regularly. In fact, such is encouraged for young and old, ill and well, male and female, athlete and non-athlete, if the key words suitable and regular are heeded.

But sport is a convenient mechanism of exercise because it has appeal and is loaded with teachable moments. Many youth are motivated to indulge in a well-balanced conditioning program and are receptive to learning the concepts involved as a result of this appeal that sport has for them. This motivational advantage produces faithful adherence to health practices which for some of these boys could never otherwise be expected.

Actually, the training necessary for safe participation in sports contributes more to health and fitness than participation in the game itself. From this point of view, for example, football should contribute as much to the health of the 4th stringer—if his interest is maintained—as to the so-called star.

Evaluation of Safeguards

Safeguarding the athlete must be considered primarily as a *positive program of prevention* of any health problem that could lead to impaired performance if not serious disability. With the implications already discussed in mind, let us move on to a brief discussion of the five categories that athletic leadership needs to periodically evaluate; proper conditioning; careful teaching, good officiating; right equipment and facilities; and adequate medical care.

Proper Conditioning

Through no other means than proper conditioning can the athlete so effectively both approach his performance potential and increase his resistance to injury and fatigue. Muscles supporting joints are strengthened. Cardiovascular efficiency is increased. Acclimation to the environment is attained. Overall readiness for the demands of present-day competitive standards is enhanced.

Such a conditioning program obviously cannot begin a week or two before the first game and

be effective. Ideally, it is an ongoing year-round process and practice. This enables the athlete to enter the season ready to spend more of his workouts in refinement of skill rather than on the frustrating and potentially hazardous procedures of crash-conditioning.

At a minimum, however, three weeks of formal practice should precede the first game or meet with at least the first week devoted primarily to progressive conditioning. The hazardous aspects of that sport should not be approached until the level of fitness is commensurate with the exposure. Finally, and frequently neglected, conditioning must continue throughout the season and not become obsolete after the first game or two.

Careful Teaching

The coach as an educator must develop his students' skills and attitudes that lead both to improved performance and decreased vulnerability to injury. Fortunately, most techniques and practices that are taught to improve performance are effective and necessary to decrease vulnerability as well. The well-being of the enthusiastic but awkward unskilled athlete is certainly put in jeopardy when matched against the speed, power and agility of the skilled athlete of the same physical proportions.

Concurrent with the development of skill should be "education for sport," an understanding of the rules within the philosophical framework of sportsmanship. The athlete must assume responsibility for his actions, and a major task of the coach is to help him fully comprehend the meaning and consequences of his behavior. Off the field, the same is true. With all the possible health problems that, while technically minor, can cause significant effects on peak performance, the coach cannot possibly personally supervise the daily health habits of each athlete.

The training schedule, broadened in perspective, should be utilized as a comprehensive health education program. Its "curriculum" should cover principles involved in personal hygiene, first aid, medical and dental care, rest and exercise, communicable disease control, environmental hazards, and accident prevention. What better laboratory for demonstrating meaningful relations of health to performance could one expect?

Conversely, coaching that advocates unsound health practices as essential to achievement, such as in the area of nutrition, is indefensible —by either criterion of winning or health. Whether or not such gimmicks, such substitutes for competent coaching, are hazardous, misleading, or simply unnecessary, the athlete who is so psyched is relying on a crutch for success and satisfaction instead of progressive development of his natural resources.

The disinterested or stale athlete is another candidate for being a statistic instead of a star. The coach as a tactician therefore must maintain motivation and alertness in all of his team members over the entire season. Practice periods should be planned to provide incentive, meaning and satisfaction. Also, game strategy that is progressive over the season and built on the increasing capabilities and skills helps keep the squad attentive and absorbed at all times.

Sensitivity to the emotional and physical tolerance levels of each athlete also prevents many health problems. By being aware of the norm of each individual, the coach can better detect and evaluate any deviation such as indifference, recklessness, incoordination, or fatigue which could lead to injury or which reflects the existence of significant but subtle injury.

Good Officiating

From pre-game inspections to the final game decision, the official is expected to have complete and immediate command of the rules, players and game. He must preserve not only the enjoyment of participation, but also the safety of the players. By staying alert to possible inadequacies existing in the rules and to the specially hazardous situations that may occur during the game, he can prevent more injuries than even he may recognize. Considering that he is the only impartial person involved in athletics, the importance of the official cannot be overstated.

Officiating, by the way, is not confined to the conduct of interscholastic games. If officiating during practice sessions is substandard, the athlete is apt to carry over to the contest dangerous and improper habits and attitudes.

Right Equipment and Facilities

Coaches and athletic administrators play a major role in safeguarding the athlete whenever protective athletic equipment is purchased. The basic principles for optimum protection are: the best available equipment be obtained, properly fitted, conscientiously maintained, and faithfully worn.

Inferior equipment gives the wearer a false sense of security and puts him in jeopardy of serious injury. Superior equipment on the other hand can give its wearer such a sense of invulnerability that normal protective inhibitions are

abandoned and new preventive measures may become warranted.

The football helmet provides a cogent example. With the advent of telemetry, the degree and direction of the forces of impact in game conditions can now be evaluated. In several (collisions of line backer to fullback), over 5000 G forces have been generated. The studies are definitely proving the necessity of the helmet containing shock-absorbing material encased in a rigid plastic shell. A clue to better design has been found in that the majority of blows are received around the periphery of the helmet not the top. Optimum protective effectiveness of the helmet, however, implies more than its design. The practice of utilizing this protective equipment as a weapon instead of a safeguard is indefensible and can produce injury to both the aggressor and opponent.

Regular, careful maintenance and inspection of equipment and facilities is basic to the athletic program, yet is easily neglected or superficially handled because of the dulling effect of routine. Divots in the turf of the gridiron or in the infield skin of the baseball diamond are but two examples. Also, changes in game arrangements or facilities can be made for various reasons without thinking through new safety concerns.

Adequate Medical Care

Arranging for medical supervision is an essential prerequisite to the offering of an athletic program and the decisions of the physician vested with such responsibility cannot be averted by anyone.

A pre-participation medical evaluation utilizing examination and medical history is fundamental. Any limitation to normal competitive conditions must be determined before the athlete is allowed to participate. The aspiring athlete with one eye or kidney, for example, should be advised against playing a sport in which the injury potential to the remaining paired organ is great. Yet, such an athlete should be positively guided to a sport in which he can participate. Undue restriction from sports is an abuse just as are the other problems already discussed.

The physician can help the coach incorporate the desired health education program for his athletes. For example, special precautions such as immunization against tetanus or prevention of heat exhaustion should be understood, not merely followed.

The physician should be present at games, especially for the more hazardous sports. During practice when one may not be present, written procedures for handling emergencies should be available and known to all concerned. Instructions for reaching the designated physician, and for obtaining immediate safe transport when necessary should be included.

Every effort should be made to have all athletic personnel competent in first aid techniques and practices. At all times, the coach and trainer must realize the distinction between recognition and diagnosis, first aid and treatment. The temptation to fail to make these distinctions are strong because of the interest of the boy, the coach, and the fans in the rapid return of the injured athlete to action.

The team physician is just as interested as the coach in seeing an athlete continue to participate when he can do so safely. Yet, the aggravated injury is usually the most severe injury and must be guarded against. Future unimpaired participation—that season, the next season and for a lifetime—may be at stake.

The Long Look

In summary, I would like to graduate these athletes and look ahead. Will they transform their training regimen just ended into a pattern for daily living? Whether they remain in condition and continue to reap the values of athletics depend upon the extent to which they continue to exercise and to follow principles of healthful living. After all, the physiological law of atrophy from disuse pertains to athletes as well as to non-athletes.

Hopefully our educated graduate has gained a firm foundation of philosophy, facts and experiences suitable for judgment on matters that should safeguard not only his personal health in adult life, but that of his family and community around him as well.

Sports, therefore, can exercise a profound positive impact on the health of the athlete, if the adults associated with the program (parents as well as coaches) provide an example with which the athletes can desirably identify; if the program is geared primarily to the needs of the athletes, and if the direct leadership of the teams exercises care and judgment in safeguarding the health of the athlete. If this is not the case, abuses are the result and the assumptions of justification for conducting sports in the school setting are violated. But neither the abuses or values attributed to sports are automatic outcomes. Rather, they are the result of the combined and shared responsibilities of all involved in athletics —the educator, athletic director, coach, trainer, parent, athlete and community citizen.

That this Conference is co-sponsored not only by the medical profession, but the specifically

organized section of your medical community which is vitally interested in the values of sports, is certainly evidence of the benefits from such mutual responsibility.

After all, the educator, physician and coach have one vital goal in common: development of the fullest utilization of our youth's natural resources. And each possesses unique skills and services that contribute to this end. You are fortunate to live in one of the relatively few states where the State Medical Association has a Committee on the Medical Aspects of Sports. Use it!

Finally, I would like to leave one thought for those who rely only on common sense and who feel justified when nothing goes wrong. Be wary, even a broken clock tells the correct time twice a day.

Changing Values

All too frequently physicians are asked by high school students to write medical excuses based on very flimsy evidence so they may avoid all or part of activities known collectively as physical education. Some young persons say they do not like to change clothes so many times, gymnasium work makes them tired, and swimming is detrimental to some girls' hair styling. Tales of repeated colds, tonsilitis, and ear infections are told without substantiation. These alleged reasons are made up to avoid physical activity sometimes known as plain work. Bona fide cases are another matter entirely.

Regretfully we recognize a change in society's symbols. Today physical inactivity has gained appeal and status because symbolically it represents wealth. Some well-to-do students are under the impression they need not work physically. Sooner or later the delusion permeates the realm of assigned studies in schools and colleges to the detriment of the student, other students, their parents, the educational institution, the taxpayer, and society in general.

We continue to be disturbed about the time students try to stay out of physical education classes after very simple injuries. Could it be they have observed a parent exploit compensation after minor injury? Most of the activity in and around high schools is geared to things boys and girls like in order to keep from being bored. Youth lives in a changing world where boredom may be a way of life. Since they have difficulty finding work, physical or otherwise, we are inclined to favor suitable sports that are well supervised. Indeed some bored adults could change their outlook on life by indulging in medically prescribed sports.

Occasionally some one gets injured in football or other contact sports but great efforts are made to protect them and gradually boys learn how to defend themselves. The risk in supervised play is less than playing ball in the street. Games help concentration, speed of action, reaction, coordination, and cooperation. Some boys have aggressions better worked out in supervised football and other programs than in switchblade contests in back alleys or in "peeling rubber" off the tires by fast starts of dad's automobile—a far more lethal weapon than any contact ball game.

Sports are medically sound.—Charles Sellers, M. D., in Detroit Medical News.

In Memoriam

Norman A. Welch, M. D.

Died September 3, 1964

While Serving As President

of

The American Medical Association

The President's Page

'MOUNTAINEERS ARE ALWAYS FREE'

FROM the time of antiquity to the first Code of Ethics of King Hammurabi, 2100 years before Christ; the Oath of Hippocrates in the third century B.C.; the Code of Percival in the seventeenth century; and to this very day, we, who are descendants of the heritage of the practice of medicine have been a profession of free men. In the Senate of the United States in this past month, the first step leading toward the socialization of medicine was passed. No matter what action is taken in the House of Representatives, the die is cast. Now as never before, whether you are a Democrat or Republican, as mountaineer physicians, the time has come for your active participation in this coming election campaign.

Let the candidates know your strong feeling to remain free and add your physical, moral and financial support to electing those candidates who would not lead us down the road to socialized medicine and a welfare state, but who are sincere and dedicated to good government and who will uphold the original intent of the Constitution of this great land of ours. Your mightiest single weapon is your daily communication with the voters of our State—a fact that makes certain politicians most anxious to subjugate medicine by socialization.

Like our State motto, let us resolve that "Mountaineer Physicians Are and Always Will Be Free."

As this goes to press, we have learned of the tragic and sudden death of Dr. Norman A. Welch, President of the American Medical Association. Those of you who met, heard and talked with him just so recently at the Greenbrier, know of our great loss. "Almighty God, may his soul rest in peace."

Albert C. Esposito

Albert C. Esposito, M. D., President

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EDITORIALS

THE NEW PRESIDENT

Members of the West Virginia State Medical Association have been fortunate through the years to have had as their elected officers physicians who were well versed in the activities of organized medicine. The physician who will serve as President during the coming year certainly is no exception to this rule.

Dr. Albert C. Esposito, who has practiced his specialty of ophthalmology in Huntington since 1946, became active in medical affairs immediately after entering practice. This interest has never waned and his ability as a leader was recognized when he was named in 1963 as President Elect of the Association.

Doctor Esposito served as President of the Cabell County Medical Society in 1958 and a term as President of the West Virginia Academy of Ophthalmology and Otolaryngology, 1961-62.

A native of Pittsburgh, Doctor Esposito was graduated from the University of Pittsburgh and received his M. D. degree in 1938 from the Stritch School of Medicine of Loyola University in Chicago. He was graduated cum laude. He served his internship at the University of Pittsburgh Teaching Hospital and St. Francis Hospital in Pittsburgh, 1938-39, and a residency in ophthalmology at the Ohio State University College of Medicine, 1940-44. Prior to locating his practice in Huntington, he served as an instructor in the Department of Ophthalmology at the Ohio State University College of Medicine.

During World War II, Doctor Esposito served in the Medical Corps of the United States Army and was released with the rank of Major. He was certified by the American Board of Ophthalmol-

Albert C. Esposito, M. D.

ogy in 1950 and that same year was elected a Fellow of the American Academy of Ophthalmology and Otolaryngology, and a Fellow of the American College of Surgeons. He is a Fellow of the Societe Francaise D'Ophthalmologie, Paris, France, and a member of the Oxford Ophthalmological Congress, Oxford England.

He has been active for many years in the Southern Medical Association and is currently serving a five-year term as Councilor from West Virginia. He is serving this year as a member of the Executive Committee and as a member of the Advisory Committee to the Editorial Board of the *Southern Medical Journal.* He served four years as Secretary of the Section on Ophthalmology and Otolaryngology of the Southern Medical Association and was elected in 1963 as Chairman of the new Section on Ophthalmology.

Doctor Esposito has maintained an active interest in civic affairs and has served as senior attending ophthalmologist at three Huntington hospitals and as Chairman of the Department of Ophthalmology at St. Marys Hospital since 1950. He also serves as consultant in Ophthalmology at the VA Hospital in Huntington.

He is the author of numerous papers which have appeared in state and national scientific journals.

Doctor Esposito is married to the former Vernon Elizabeth Dodson of Lexington, Kentucky, and they have three children, Elizabeth Ellen, Gregory and Mary Alice.

We look forward to Doctor Esposito's leadership in the months ahead and pledge to him our full support and cooperation.

All reports indicate that the 97th Annual Meeting at The Greenbrier was most successful in every respect. Although the attendance dropped slightly, it was encouraging to note that participation in the scientific and business sessions was greater than in past years. This is especially pleasing to the members of the committee responsible for arranging the program.

Without exception, the visiting lecturers were high in their praise of the meeting. One speaker wrote: "The members and officers of the association went the second mile in making our stay such a pleasant experience and the hotel, without a doubt, is the most beautiful in which we have stayed. . . ."

The Committee appointed by Doctor Esposito to arrange the program for the 98th Annual Meeting is already busy and we can look forward to another interesting and enjoyable stay at The Greenbrier in 1965.

MEDICAL SCHOOL APPLICANTS DURING THE LAST DECADE

For several years since 1956 there was a disturbing downward trend in first-year medical school applicants. According to a datagram (February 1964) distributed by the Association of American Colleges there has been a reversal between the years of 1961-62. It is suggested that this upswing will continue.

In 1961 there were 14,381 applicants to medical schools in the United States, but in 1962 the number increased to 15,847, an increase of 10 per cent. It is estimated that in 1963 there were 17,500 applicants, and in 1964, 19,500. The number of applications, of course, greatly exceed the number of applicants since the majority of students apply to more than one medical school. In 1961 there were 59,054 applications made. It was conservatively estimated that in September 1963 there would be 70,000 and 78,000 for 1964.

As would be expected, the number of places in the freshman class has also shown an increase. In 1954 there were 7,576 places, and in 1963, 8,642, an increase of 14 per cent. For 1963 and 1964 class sizes were estimated to be 8,700 and 8,800 respectively. These are indeed substantial increases.

In considering applicants to medical schools it is pertinent to assess the number of 22-year olds in the United States. This age group remained relatively constant from 1954-1961, but since the latter year the number has risen substantially. In 1954 there were 2,440,000 22-year olds; in 1963 it was estimated that there were 2,703,000, and in 1964, 2,989,000. It is pointed out in the datagram that the upswing of birth rate beginning in 1940 may account in large part for the recent rise in application activity. There presumably are other contributing factors, such as general recruiting efforts and increased financial aid for prospective medical students.

In summary, it is gratifying that the downward trend in first year medical school applicants has been reversed. There is sound evidence that some of the best students in late years have been entering the fields of chemistry, engineering, mathematics, and nuclear physics. It is highly important, of course, that these areas attract outstanding students, especially in this scientific age. On the other hand, obviously, medical educators are most anxious to see a good percentage of top flight students choose a medical career.

NURSING PROGRAM AT MORRIS HARVEY COLLEGE

The creeping, and then rapidly expanding, nursing shortage in the Kanawha Valley and all of West Virginia has been a topic of conversation for some time. Morris Harvey College and seven area hospitals have worked cooperatively toward the solution of the problem and this effort has resulted in a two-year Associate-in-Nursing program at the College which opened in September of this year.

Recognizing that new programs cost sizable amounts to become properly established, the Kanawha Medical Society appointed a committee to work with the College. The Society agreed to a campaign among its members to provide funds for laboratories and equipment, for library books, and for scholarships and loans. The campaign expanded to include patients of the doctors and other friends and businesses. The efforts of this committee of the Society and a small group of volunteer workers have resulted in gifts totaling $98,228 toward an estimated need by the College of $135,000.

Most of the above gifts were unrestricted other than they were to be used in the area of nursing. The College has indicated these would be utilized for laboratories and equipment. The committee from the Society is continuing its efforts in the hope that the need will ultimately be met.

This nursing problem affects each of us in our practice. Nurses with quality training must be made available in ever-increasing numbers to insure that our patients who need special bedside care will receive what they can reasonably expect and what we as medical doctors should demand.

In Re the Welfare State

Too frequently arguments for or against national compulsory health care ("Socialized Medicine") are lost in elaborate charts and tables coupled with statistical analyses that create confusion and delete personal and individual considerations which are the heart of the matter. A recent letter from London, written by an intelligent English woman who had major surgery in this country several years ago, throws penetrating light upon the problem which says more than voluminous official health service reports can ever say. It is refreshing to be able to reprint a part of her letter:

I've had absolutely no trouble with my back since I saw you. It is behaving wonderfully well. This is particularly encouraging for me, because now I am pregnant, and I am expecting the babe at the end of July. As you can imagine, I am very thrilled and happy about this; so is Tony. I feel confident that my back will continue to behave. This is marvelous, because I know I'd have been scared if it had continued as bad as it was before I saw you.

I am being looked after by the National Health Service—and how I hate it! I know that medically it is good, and everything is checked and looked after, and this is the main thing, of course. But you are made to feel exactly like a sausage in a machine, and not at all like a human being, and you can't help wishing someone took a little interest in you. We pay a lot of money over the years for the Service, and yet the attitude is that we are a considerable nuisance, and they are doing us a favor! Ah well—c'est la vie—or anyway, the welfare state.

It poignantly sums up what we have been saying for many years. "They make you feel just like a sausage in a machine." The truly good medical care, as we know it, has as its keystone the secure knowledge and confidence that the patient's physician is his doctor, and that he is interested in the patient as an individual, and not as a "sausage in a machine."—Irvin E. Hendryson, M. D., in Rocky Mountain Medical Journal.

The Doctor's Drug Dilemma

Regulations under the Federal Food, Drug, and Cosmetic Act of 1962 require more stringent evidence of safety for new drugs. Included are tests for genetic and teratogenic effects over several generations of animals. Usefulness as well as safety is introduced as a criterion of acceptability of new agents.

There are also, unfortunately, provisions regarding labeling that are interpreted as prohibiting interstate shipment of placebos required in double-blind tests. And the whole act has generated an increasingly undigestible bolus of reports, forms and other paper that make life unhappy for pharmaceutical firms, investigators, and government officials. A fair estimate of the act lies somewhere between the view that this is another horrible example of government control over free enterprise, and the view that it will solve all problems.

In any case, the medical profession is square in the middle of the issues and cannot avoid being involved. Mere opposition would represent a withdrawal syndrome that invites further restrictions. Complete acquiescence would imply a confidence in Washington approaching delusional euphoria.—Michael S. Shimkin, M. D., in Public Health Reports.

Health Insurance Benefits

In 1963, insurance companies paid out nearly $700 million in benefits to insured persons to help them pay for the cost of surgery, the Health Insurance Institute reported recently.

The $695,000,000 in surgical benefits was an increase of 10.6 per cent over the $629,000,000 paid out by insurance companies in 1962. The payments include all benefits under surgical expense policies, and those benefits under major medical insurance policies that went toward surgical bills.

At the end of 1963, 85 million persons had surgical expense insurance through insurance companies.

GENERAL NEWS

Dr. Esposito Installed as President Of State Medical Association

Dr. Albert C. Esposito of Huntington was installed as President of the West Virginia State Medical Association by Dr. Charles L. Goodhand of Parkersburg, the immediate past president, at the final session of the House of Delegates during the 97th Annual Meeting at The Greenbrier on Saturday afternoon, August 22.

Doctor Goodhand automatically becomes Chairman of the Council of the State Medical Association.

Dr. Charles L. Goodhand of Parkersburg, left, immediate past president of the West Virginia State Medical Association, passes the gavel to his successor, Dr. Albert C. Esposito of Huntington. Doctor Esposito was installed during the 97th Annual Meeting at The Greenbrier, August 20-22.

Doctor Esposito served four years as a member of the Council and was elected vice president in 1962 and president elect in 1963.

Dr. Seigle W. Parks President Elect

Dr. Seigle W. Parks of Fairmont, who was named vice president in 1963, was named president elect. He will be installed as president at the 98th Annual Meeting at The Greenbrier in August, 1965.

Dr. Richard E. Flood of Weirton, a former member of the Council, was elected vice president. He also served during the past year as a member of the Legislative Committee.

Dr. Daniel N. Barber of Charleston was reelected treasurer, a post he has held since 1958.

Dr. L. J. Pace of Princeton, who has served during the past year as Chairman of the Council, will serve as Councilor-at-Large during the coming year.

Three New Members of The Council

Three new members of Council were elected as follows:

Dr. G. Thomas Evans of Fairmont (first district); Dr. Andrew J. Weaver of Clarksburg (third district); and Dr. A. J. Villani of Welch (fifth district).

The new members succeed Drs. Paul P. Warden of Grafton, Richard V. Lynch, Jr., of Clarksburg, and Ward Wylie of Mullens.

Three Council Members Reelected

Three members of the Council were reelected to serve terms of two years. They had served but one full term or part of a term and were eligible for reelection. They are as follows:

Dr. Charles L. Leonard of Elkins (second district); Dr. Richard W. Corbitt of Parkersburg (fourth district); and Dr. William B. Rossman of Charleston (sixth district).

Neighboring State Presidents Attend Annual Meeting

The presidents of the medical associations of the neighboring states of Ohio, Pennsylvania, Virginia, Maryland, and Kentucky were among the honor guests at the 97th Annual Meeting at The Greenbrier in August. The following physicians, all of whom were accompanied by their wives, attended the meeting:

Dr. Robert E. Tschantz of Canton, Ohio, president of the Ohio State Medical Association; Dr. Albert E. Goldstein of Baltimore, president of the Medical & Chirurgical Faculty of the State of Maryland; Dr. Richard E. Palmer of Alexandria, Virginia, president of the Medical Society of Virginia; Dr. Wilbur E. Flannery of New Castle, Pennsylvania, president of the Pennsylvania Medical Society; and Dr. George P. Archer of Prestonsburg, Kentucky, president of the Kentucky State Medical Association.

Doctor Hoffman Reelected AMA Delegate

Dr. C. A. Hoffman of Huntington was reelected AMA Delegate from West Virginia and Dr. D. E. Greeneltch of Wheeling was reelected as AMA Alternate. Each will serve a two-year term beginning January 1, 1965. Dr. Frank J. Holroyd of Princeton is the holdover AMA delegate and Dr. Thomas G. Reed the holdover alternate.

New President Native of Pittsburgh

Doctor Esposito, the new president, is a native of Pittsburgh, Pennsylvania. He was graduated in 1933 from the University of Pittsburgh and received his M. D. degree cum laude in 1938 from the Stritch School of Medicine of Loyola University in Chicago.

He served his internship at the University of Pittsburgh Teaching Hospital and St. Francis Hospital in Pittsburgh, 1938-39, and a residency in ophthalmology at the Ohio State University College of Medicine, 1940-44. He was an instructor in the Department of Ophthalmology at the Ohio State University College of Medicine, 1944-47.

Doctor Esposito established his practice in Huntington in 1946 and was certified by the American Board of Ophthalmology in 1950. That same year he was elected a Fellow of the American Academy of Ophthalmology and Otolaryngology.

During World War II, Doctor Esposito served in the Medical Corps of the United States Army and was released with the rank of Major.

He served as president of the Cabell County Medical Society in 1958 and a term as president of the West Virginia Academy of Ophthalmology and Otolaryngology, 1961-62.

Doctor Esposito served two terms as a member of the Council of the State Medical Association and was named vice president in 1962 and president elect in 1963.

Dr. Norman A. Welch of Boston, left, President of the American Medical Associations, chats with AMA Field Representative Harry Hinton of Chicago, and Dr. Wilbur E. Flannery of New Castle, Pennsylvania, President of the Pennsylvania Medical Society. Doctor Welch, who died suddenly on September 3, was guest speaker at the first session of the House of Delegates.

He has maintained an active interest in civic affairs and has served as senior attending ophthalmologist at three Huntington Hospitals and as chairman of the Department of Ophthalmology at St. Mary's Hospital in that city.

He has long been active in the Southern Medical Association and currently is serving as Councilor from West Virginia. He was named chairman of the Section on Ophthalmology in November, 1963.

Doctor Esposito is married to the former Vernon Elizabeth Dodson of Lexington, Kentucky, and they have three children, Elizabeth Ellen, Gregory and Mary Alice.

The President Elect

Dr. Seigle W. Parks, the president elect, is a native of Middlebourne in Tyler County. He was graduated from West Virginia University and attended the two-year School of Medicine at West Virginia. He re-

Eight members of the faculty of the West Virginia University School of Medicine participated in a Symposium on Thyroid Disease at the third general session on Saturday morning. Shown above, left to right, Drs. George G. Green, Victor M. Napoli, W. Gene Klingberg, Alvin L. Watne, Edmund B. Flink, John E. Jones, Paul C. Desper and Clark K. Sleeth, Dean of the WVU School of Medicine.

Dr. J. P. McMullen of Wellsburg, left, Chairman of the Committee on Medical Education, Hospitals and Scholarships, is shown with Carl E. Nichols of Glenville and Byron L. Van Pelt of Bethany, recipients of four-year scholarships to the West Virginia University School of Medicine.

ceived his M. D. degree in 1939 from the University of Maryland School of Medicine.

He served an internship and residency at St. Agnes Hospital in Baltimore, 1939-41.

Doctor Parks was licensed to practice in West Virginia in 1940 and in 1942 entered the Medical Corps of the United States Army. He was released in 1946 with the rank of Major after service in the European Theatre of Operations.

He is a former member of the Council of the State Medical Association and a past president of the West Virginia Chapter of the American Academy of General Practice. He also served for a number of years as Editor of *Mister Doc*, official publication of the Chapter.

Resolutions Committee Meeting

The Committee on Resolutions held an open hearing on seven resolutions lodged with the executive secretary at least two weeks prior to the first day of the meeting. The meeting was held on Thursday afternoon, August 20, and was attended by a number of interested physicians in addition to members of the Committee.

The report of the Committee, which appears elsewhere in this issue of *The Journal*, includes the resolutions adopted by the House of Delegates at the second session on Saturday afternoon, August 22.

Addresses by Drs. Goodhand and Gresham

Dr. Charles L. Goodhand of Parkersburg, the retiring president, delivered his Presidential Address at the second session of the House of Delegates on Saturday afternoon. The complete text of Doctor Goodhand's address appears elsewhere in this issue of *The Journal*, beginning on Page 277.

Dr. Perry E. Gresham, President of Bethany College, was the first speaker at the opening session on Thursday morning, August 20.

Scholarship Winners Introduced

Carl E. Nichols of Glenville and Byron L. Van Pelt of Bethany were introduced at the second session of the House of Delegates by Dr. J. P. McMullen of Wellsburg, Chairman of the Committee on Medical Education, Hospitals and Scholarships, as recipients of the 1964 medical scholarship awards.

Nichols and Van Pelt are the ninth and tenth students to receive medical scholarships under the program which was inaugurated in 1958. In years prior to 1962, only a single scholarship was awarded.

1965 Meeting at The Greenbrier

The House of Delegates, prior to adjournment on Saturday afternoon, voted unanimously to return to The Greenbrier for the 98th Annual Meeting in 1965. The Council fixed August 26-28 as the dates for the coming year.

The total attendance for the meeting was 627, which compares with 659 in 1963. The physician registration was 389 compared to 419 last year. The Auxiliary registration was 138 and the total registration for exhibitors and other guests was 100.

Dr. Charles L. Goodhand of Parkersburg, left, immediate past president of the State Medical Association, is shown with Dr. Bayard Carter of Durham, North Carolina, a guest speaker and Professor of Obstetrics and Gynecology at the Duke University School of Medicine. In the other photo,

Dr. Seigle W. Parks of Fairmont, second from right, the president elect, is shown with Drs. Carl B. Hall and William B. Rossman of Charleston and Maynard P. Pride of Morgantown.

Dr. John C. Krantz, Jr., of Baltimore, second from right, is shown with a member of the AMA's Department of Medicine and Religion and two former students at the University of Maryland School of Medicine. Left to right, Mr. Arne Larson of Chicago, and Drs. Tracy N. Spencer, Jr., of South Charleston, and Dwight P. Crnikshank of Parkersburg.

Pre-Convention Council Meeting At The Greenbrier, Aug. 19

The pre-convention meeting of the Council was held at The Greenbrier in White Sulphur Springs on August 19, 1964, with the Chairman, Dr. L. J. Pace of Princeton, presiding.

Dr. Hu C. Myers of Philippi, Chairman of the Committee on Constitution and By-Laws, reported that the Committee had met earlier in the afternoon to discuss several proposed amendments to the By-Laws of the Association.

He said that six of the amendments would establish standing committees of the Association, while the others pertained to clarification of the disbursement of funds of the Association and the deletion of a section in the By-Laws calling for the selection of a "General Practitioner of the Year" annually.

The Council approved the recommendations of the Committee and the Chairman was requested to report this action to the House of Delegates.

Scholarship Program

Dr. E. Lyle Gage of Bluefield, Chairman of a Special Committee Named to Study the Scholarship Program of the Association, reported that the Committee had met on several occasions during the past year.

Dr. J. P. McMullen of Wellsburg, Chairman of the Committee on Medical Education, Hospitals and Scholarships, also presented a report. He stated that the members of his committee, and the members of the special committee under the chairmanship of Doctor Gage, were in complete agreement concerning the operation of the Association's scholarship program. He also expressed appreciation to the members of Doctor Gage's committee for the manner in which they carried out the responsibilities given to them by the House of Delegates in 1963. The Council approved the reports presented by Drs. Gage and McMullen. (See Page 319).

Preceptorship Program

The Council approved the appointment of Dr. S. William Goff of Parkersburg as the representative of the Association to serve on a Preceptorship Committee which will be responsible for the direction of such a program at the WVU School of Medicine. It was reported that the program would be initiated during the 1964-65 school year

The Council also approved the designation of Dr. Charles L. Goodhand as the Association's official representative at a seminar on "The Place of Training in General Practice in Undergraduate Medical Education" scheduled to be held at the Medical College of Virginia in Richmond, October 2-3.

Honor Guests Attend Meeting

In addition to officers and members of the Council, the following honor guests attended the meeting and spoke briefly:

Dr. Norman A. Welch of Boston, President of the American Medical Association; Dr. Russell B. Carson of Fort Lauderdale, Florida, Chairman of the Board of Directors of the National Association of Blue Shield Plans; Dr. Wilbur E. Flannery, President of the Pennsylvania Medical Society; and Dr. George P. Archer, President of the Kentucky State Medical Association.

Medical Examiner's System

Dr. Richard W. Corbitt of Parkersburg, member of the Council and Chairman of the Commission on Postmortem Examinations, presented a progress report on the Medical Examiner's System which was established by an act of the Legislature in 1963.

Doctor Corbitt explained that implementation of the law had been hampered due to the fact that the legislature failed to appropriate operating funds during both the 1963 and 1964 sessions. He stated that much thought had been given to the 1965-66 budget request

Dr. O. W. Ladwig, 88, of Wilsonburg, Harrison County, left, is shown with Dr. George F. Evans of Clarksburg, Editor of The Journal and a past president of the State Medical Association. Doctor Ladwig, who is still active after 59 years of practice, was honored as West Virginia's "General Practitioner of the Year" for 1964.

and that it was hoped that the Commission could be placed into operation at the beginning of the next fiscal year.

Selection of Dates for 1965 Meeting

It was reported that The Greenbrier was holding the dates, August 26-28, 1965, for the 98th Annual Meeting of the West Virginia State Medical Association.

The Council went on record unanimously as approving the above mentioned dates for the 1965 meeting.

Praise for Retiring Councilors

Doctor Goodhand reported that Drs. Paul P. Warden, Richard V. Lynch, Jr., and Ward Wylie had completed four years of service as members of the Council and therefore were not eligible for reelection.

The Council went on record as commending Dr. L. J. Pace, the Chairman, and the three retiring councilors for their outstanding service during the past year.

The following members of the Council were present at the meeting: Dr. L. J. Pace of Princeton, Chairman; Dr. Charles L. Goodhand of Parkersburg, President; Dr. A. C. Esposito of Huntington, President Elect; Dr. Seigle W. Parks of Fairmont, Vice President; Dr. D. E. Greeneltch of Wheeling, Councilor-at-Large; and Drs. Joseph L. Curry, Wheeling; Charles L. Leonard, Elkins; Maynard P. Pride, Morgantown; Richard V. Lynch, Jr., Clarksburg; John E. Echols, Richwood; I. Ewen Taylor, Huntington; Ward Wylie, Mullens; Buford W. McNeer, Hinton; Richard W. Corbitt, Parkersburg; William B. Rossman, Charleston; and D. Alene Blake, Oak Hill; and Mr. William H. Lively, secretary ex-officio.

The meeting was also attended by Dr. Frank J. Holroyd, Princeton, and Dr. C. A. Hoffman, Huntington, AMA Delegates; Dr. Thomas G. Reed, Charleston, AMA Delegate; Dr. George F. Evans, Clarksburg, Editor of *The Journal*; Dr. James S. Klumpp, Huntington, Parliamentarian; Dr. N. H. Dyer, Charleston, Director of the State Department of Health; Dr. George R. Callender, Jr., Charleston, Chairman of the Medical Economics Committee; Dr. John W. Hash, Charleston, Chairman of the Budget and Personnel Committee; Dr. J. P. McMullen, Wellsburg, Chairman of the Committee on Medical Education, Hospitals and Scholarships; Dr. Hu C. Myers, Philippi, Chairman of the Committee on Constitution and By-Laws; Dr. E. Lyle Gage, Bluefield, Chairman of Special Committee Named to Study the Scholarship Program; Dr. Edwin M. Shepherd, Charleston; Dr. Andrew J. Weaver, Clarksburg; and Dr. W. P. Bittinger, Summerlee; and Mr. Harry Hinton of Chicago, AMA Field Representative.

1965 Meeting at The Greenbrier

At the final session of the House of Delegates on Saturday, August 22, it was ordered by the unanimous vote of the delegates present that the 98th Annual Meeting of the State Medical Association be held at The Greenbrier in 1965. The meeting is scheduled for August 26-28.

Dr. D. E. Greeneltch of Wheeling, a past president of the State Medical Association, is shown with Mrs. Betty Bowie and Mrs. Charles L. Goodhand of Parkersburg before the opening session of the House of Delegates.

Dr. J. Bernard Poindexter Honored By House of Delegates

Dr. J. Bernard Poindexter, a practicing dentist in Huntington, was recognized by the House of Delegates of the West Virginia State Medical Association for his outstanding service in the State Legislature. Doctor Poindexter has served four terms as a Delegate from Cabell County.

Doctor Poindexter received his D. D. S. degree from the University of Louisville School of Dentistry and he is a past president of the West Virginia State Dental Society.

The following resolution was approved unanimously by the House of Delegates:

"Whereas, During eight years' service in the House of Delegates of the West Virginia State Legislature, the Honorable J. Bernard Poindexter, Huntington Doctor of Dental Surgery, has established an outstanding record in the fields of public health and medical science; and

"Whereas, As a member of the House of Delegates for four terms, Dr. Poindexter has proved an able and effective advocate of legislation designed to improve our public health laws and advance the medical profession, always supporting desirable legislation and opposing proposals detrimental and inimical to the progress and welfare of our profession;

"Therefore, be it resolved, By the West Virginia State Medical Association in annual meeting assembled that the Association does hereby express its gratitude and appreciation to Dr. Poindexter for his enviable record in behalf of public health and the medical profession, and his effective and consistent support of proposals and programs having as their ultimate objective the general welfare of society; and

"Be it further resolved, That the Executive Secretary of the West Virginia State Medical Association transmit a copy of this resolution to Dr. J. Bernard Poindexter."

Amendments to By-Laws Adopted By House of Delegates

Several amendments to the By-Laws of the West Virginia State Medical Association were adopted by the House of Delegates during the final session on Saturday afternoon, August 22.

The amendments were offered at the first session on Wednesday evening, August 19, by Dr. Hu C. Myers of Philippi, Chairman of the Committee on Constitution and By-Laws.

'GP Of The Year' Section Deleted

Acting on a recommendation of the Council, the House of Delegates voted to delete Section 10 of Chapter 7 of the By-Laws, which pertains to the selection of a "General Practitioner of the Year." It was pointed out that the American Academy of General Practice does not look with favor upon such awards and further that the American Medical Association discontinued its selection of a national "General Practitioner of the Year" several years ago.

Another amendment was adopted which clarifies the procedure to be followed in the disbursement of funds by the Council and the Committee on Medical Scholarships.

New Committees Established

Several new standing committees were provided for in the adoption of the following amendments to the By-Laws:

(1) Amend Chapter VIII, Section 1, By-Laws. as follows: Delete "Committee on Medical Education, Hospitals and Scholarships" and substitute therefore. (a) "Committee on Medical Education and Hospitals," and (b) "Committee on Medical Scholarships."

(2) Amend Chapter VIII. Section 5, By-Laws, as follows: Delete subsection (i) and substitute therefore: (a) Committee on Medical Education and Hospitals. This Committee shall make a continuing study of all problems associated with pre-medical, medical and postgraduate medical education, and shall keep the Council and House of Delegates informed of pertinent developments and its recommendations and actions in the improvement of curricula for medical education and the provision of adequate and timely postgraduate courses, symposia and seminars for practicing physicians within the State. The Committee shall act in liaison with hospitals and hospital associations within the State to the end that adequate and improved hospital care shall be available and provided to the citizens of this State.

(b) Committee on Medical Scholarships. This Committee shall be responsible for the activation, management and control of all medical scholarship programs authorized by resolution of the House of Delegates adopted on August 24, 1957, or by any future resolution or action unless specifically directed otherwise. It shall have sole authority in the placement of recipients of this program in selected rural areas after consultation with the Committee on Rural Health, and shall be empowered to accept scholarship funds from any legitimate source. All such income shall be deposited in a medical scholarship account and shall be disbursed by the executive secretary upon order of the Committee. The Committee shall render an annual report of its management and fiscal activities to the Council and to the House of Delegates.

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(1) Amend Chapter VIII, Section 1, By-Laws, as follows: Delete "Committee on Maternal Welfare" and insert in lieu thereof "Committee on Maternal and Perinatal Fetal Welfare."

(2) Amend Chapter VIII, Section 5, By-Laws, as follows: Delete subsection (g) and insert in lieu thereof the following: (g) Committee on Maternal and Perinatal Fetal Welfare. This Committee shall endeavor to improve the conditions of maternal welfare by means of (1) lay education through appearances before womens clubs, PTAs, mother's clubs and allied organizations and by dissemination of published materials; (2) the stimulation of greater professional interest in improved obstetrical practice through discussions by competent authority before medical, nursing and hospital groups; (3) active cooperation with the Maternal and Child Health Division of the State Department of Health and with national and local health groups; and (4) assistance in the establishment and conduct of maternal care clinics. At least five members of this Committee, who have particular interest and training therein, shall be responsible as a sub-committee, for studies and actions relative to perinatal fetal mortality and morbidity directed toward an improvement in the reproduction of normal human beings. This Committee shall be authorized to accept aid from and to cooperate with competent governmental authority in the attainment of these objectives. The Committee shall report annually to the Council and to the House of Delegates.

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(1) Amend Chapter VIII, Section 1, By-Laws, as follows: Add "Committee on Medicine and Pharmacy" to the list contained in that Section.

(2) Amend Chapter VIII, Section 5, By-Laws, by the addition of the following: Committee on Medicine and Pharmacy. This Committee shall have the primary responsibility of acting in liaison with and in furthering the relations between the medical and pharmaceutical professions; in the study of and recommendations for the solution of common problems at both state and county level. The Committee shall use its influence in the appointment of members of constituent societies to local liaison committees with the local pharmaceutical organizations. The Committee shall be authorized to negotiate a "Code of Ethics for the Medical and Pharmaceutical professions" subject to final approval by the Council or House of Delegates, and shall report at timely intervals to the Council and House of Delegates.

Dr. John J. Mahood, Dr. Ralph H. Nestmann, Mrs. Mahood and Dr. Perry E. Gresham.

Dr. and Mrs. Albert C. Esposito and children, Gregory, Elizabeth Ellen and Mary Alice.

Mrs. T. Herbert Willis, Dr. and Mrs. Charles L. Goodhand and Mrs. Gwynn Bowie.

ederick A. Stenbuck, Dr. Merle S. Scherr
Dr. Maurice Kaufmann.

Dr. and Mrs. Thomas P. Lang.

Dr. Albert C. Esposita and Dr. Richard E. Flood

Dr. and Mrs. Wilson P. Smith and Dr. and Mrs. George A. Curry and two guests at the annual reception.

. Charles L. Goodhand and Dr. Thomas L.
arris.

CAMERA HIGHLIGHTS

97th Annual Meeting

WEST VIRGINIA STATE MEDICAL ASSOCIATION

The Greenbrier

Aug. 20-22, 1964

Standing and Special Committees Named by Doctor Esposito

Dr. Albert C. Esposito of Huntington, President of the West Virginia State Medical Association, has named the standing and special committees which will function during his term of office.

The list of committees, with the exception of the Committee on Medical Emergencies and Civil Defense, is as follows:

STANDING COMMITTEES

Aging

Myer Bogarad, Weirton, Chairman; Thomas H. Blake, St. Albans; John J. Brandabur, Huntington; R. L. Chamberlain, Buckhannon; Robert W. Coplin, Elizabeth; Ross P. Daniel, Beckley; E. Lyle Gage, Bluefield; Sam Milchin, Bluefield, Virginia; Wilson P. Smith and Marshall J. Thomas, Huntington.

Budget and Personnel

D. E. Greenelteh, Wheeling (1965); L. J. Pace, Princeton (1966); and Charles L. Goodhand, Parkersburg (1967).

Cancer

Chauncey B. Wright, Huntington, Chairman; F. Lloyd Blair, Parkersburg; James P. Carey, Huntington; N. W. Fugo, Morgantown; Walter H. Gerwig, Jr., Clarksburg; Charles D. Hershey, Wheeling; T. P. Mantz, Charleston; Hu C. Myers, Philippi; Dennis S. O'Connor, Huntington; W. Hampton St. Clair, Bluefield; Russell A. Salton, Williamson; and I. Ewen Taylor, Huntington.

Conservation of Vision and Hearing

Nime K. Joseph, Wheeling, Chairman; A. C. Chandler, Charleston; William K. Marple, Huntington; W. W. McKinney, Beckley; Charles M. Polan, Huntington; Ralph W. Ryan, Morgantown; Edward Shupala, Parkersburg; Edwin M. Shepherd and James T. Spencer, Charleston.

Constitution and By-Laws

James S. Klumpp, Huntington, Chairman; J. Russell Cook and Thomas J. Holbrook, Huntington; Nime K. Joseph, Wheeling; and Kenneth G. MacDonald, Charleston.

Insurance

C. A. Hoffman, Huntington, Chairman; W. P. Bittinger, Summerlee; C. Stafford Clay, Huntington; C. R. Davisson, Weston; John E. Echols, Richwood; Upshur Higginbotham, Bluefield; Charles L. Leonard, Elkins; Athey R. Lutz, Parkersburg; Richard V. Lynch, Jr., Clarksburg; Joe E. McCary, Princeton; Eldon B. Tucker, Morgantown; John L. VanMetre, Charles Town; Gates J. Wayburn, Huntington; and Lynwood D. Zinn, Clarksburg.

Legislative

Frank J. Holroyd, Princeton, Chairman; John T. Chambers, Charleston; Richard W. Corbitt, Parkersburg; George A. Curry, Morgantown; Joseph L. Curry, Wheeling; Richard E. Flood, Weirton; S. William Goff, Parkersburg; D. E. Greenelteh, Wheeling; N. B. Groves, Martinsburg; John W. Hash, Charleston; Logan W. Hovis, Parkersburg; J. C. Huffman, Buckhannon; Frank V. Langfitt, Clarksburg; Jack Leckie, Huntington; Charles W. Merritt, Beckley; David W. Mullins, Logan; Thomas G. Reed, William B. Rossman and Page H. Seekford, Charleston; I. Ewen Taylor, Huntington; David B. Thornburgh, Parkersburg; A. J. Villani, Welch; Stephen D. Ward, Wheeling; Henry F. Warden, Jr., Bluefield; and Ward Wylie, Mullens.

Maternal and Perinatal Fetal Welfare

A. J. Villani, Welch, Chairman; Jack Basman, Charleston; Clarence H. Boso, Huntington; John T. Chambers, Charleston; Thomas J. Conaty, Huntington; Robert D. Crooks, Parkersburg; Frederick H. Dobbs, Charleston; Thomas G. Folsom, Huntington; Emma Jane Freeman, Charleston; N. W. Fugo, Morgantown; George Gevas and Charles L. Goodhand, Parkersburg; C. S. Harrison, Clarksburg; William S. Herold, Charleston; Edwin J. Humphrey, III, Huntington; W. Gene Klingberg, Morgantown; E. W. McCauley, Bluefield; Charles W. Merritt, Beckley; Meryleen B. Smith, Peterstown; and Gates J. Wayburn, Huntington.

Committee on Medical Aspects of Sports

Richard W. Corbitt, Parkersburg, Chairman; J. Marshall Carter, Huntington; R. L. Chamberlain, Buckhannon; George F. Fordham, Mullens; Robert S. Gatherum, Bluefield; William E. Gilmore, Parkersburg; Henry R. Glass, Jr., Charleston; J. W. Hesen, Jr., Morgantown; Gregory B. Krivchenia, Wheeling; George Naymick, Weirton; W. H. Rardin, Beckley; George W. Rose, Clarksburg; and Harlan A. Stiles, Huntington.

Medical Economics

George R. Callender, Jr., Charleston, Chairman; D. Sheffer Clark, Huntington; A. B. Curry Ellison, Charleston; D. E. Greenelteh, Wheeling; N. B. Groves, Martinsburg; Carl B. Hall, Charleston; Grover C. Hedrick, Jr., Beckley; Henry M. Hills, Jr., Charleston; Thomas J. Holbrook and Jack Leckie, Huntington; Milton J. Lilly, Jr., Charleston; Thomas P. Long, Man; Richard V. Lynch, Jr., Clarksburg; Kenneth G. MacDonald, Charleston; J. C. Pickett, Morgantown; W. Fred Richmond, Beckley; Charles M. Scott, Bluefield; Harry S. Weeks, Jr., Wheeling; and J. D. H. Wilson, Clarksburg.

Medical Education and Hospitals

Pat A. Tuckwiller, Charleston, Chairman; Rowland H. Burns, Huntington; William E. Gilmore, Parkersburg; Richard Hamilton, St. Marys; Richard V. Lynch, Jr., Clarksburg; Thomas G. Reed, Charleston; Edwin M. Shepherd, Charleston; Clark K. Sleeth, Morgantown; William A. Thornhill, Jr., Charleston; and M. B. Williams, Wheeling.

Committee on Medical Scholarships

J. P. McMullen, Wellsburg, Chairman; Martha Jane Coyner, Harrisville; Carl B. Hall, Charleston; Thomas J. Holbrook, Huntington; Russel Kessel, Charleston; John M. Moore, Wheeling; and Clark K. Sleeth, Morgantown.

Committee on Medicine and Pharmacy

L. Dale Simmons, Clarksburg, Chairman; Andrew E. Amick, Lewisburg; R. C. Cowan, Jr., Parkersburg; and David A. Haught and Richard J. Stevens, Huntington.

Committee on Medicine and Religion

Tracy N. Spencer, Jr., South Charleston, Chairman; John C. Bryce, Parkersburg; M. Homer Cummings, Jr., Huntington; Vernon L. Dyer, Petersburg; William E. Gilmore, Parkersburg; and W. L. Neal, Huntington.

Medico-Legal

George F. Evans, Clarksburg, Chairman; C. A. Hoffman, Huntington; J. C. Huffman, Buckhannon; Hu C. Myers, Philippi; J. Keith Pickens, Clarksburg; Thomas G. Reed and Paul H. Revercomb, Charleston; B. B. Richmond, Beckley; Walter R. Wilkinson, Huntington; and E. Andrew Zepp, Martinsburg.

Mental Health

William B. Rossman, Charleston, Chairman; Mildred Mitchell-Bateman, Charleston; Randall Connolly, Vienna; Roy A. Edwards, Jr., and R. W. Hibbard, Huntington; Thomas S. Knapp, Charleston; S. Elizabeth McFetridge, Shepherdstown; L. J. Pace, Princeton; A. L. Wanner and Stephen D. Ward, Wheeling; David M. Wayne, Bluefield; William E. Wilkinson, Beckley; and A. C. Woofter, Parkersburg.

Military Medical Affairs

Russel Kessel, Charleston, Chairman; Bert Bradford, Charleston; Francis L. Coffey, Huntington; Walter H. Gerwig, Jr., Clarksburg; William E. Irons, Huntington; L. Rush Lambert, Fairmont; Paul L. McCuskey, Parkersburg; Charles M. Scott, Bluefield; Jack J. Stark, Belpre, Ohio; and Ward Wylie, Mullens.

Necrology

William F. Beckner, Huntington, Chairman; Andrew J. Weaver, Clarksburg; and P. R. Fox, Bluefield.

Program Committee

Richard J. Stevens, Huntington, Chairman; Richard W. Corbitt, Parkersburg; Jack Leckie, Huntington; Kenneth G. MacDonald, Charleston; Maynard P. Pride and Clark K. Sleeth, Morgantown.

Public Service Committee

Joseph L. Curry, Wheeling, Chairman; Robert M. Biddle, Parkersburg; John M. Bobbitt and D. Sheffer Clark, Huntington; William L. Cooke, Charleston; C. R. Davisson, Weston; G. Thomas Evans, Fairmont; S. William Goff, Parkersburg; Carl E. Johnson, Morgantown; E. Lee Jones, Wheeling; Jack Leckie, Huntington; John J. Mahood, Bluefield; Kenneth G. MacDonald, Charleston; Jack J. Stark, Belpre, Ohio; and Stephen D. Ward, Wheeling.

Resolutions

Maynard P. Pride, Morgantown, Chairman; Charles L. Goodhand, Parkersburg; Thomas J. Holbrook, Huntington; J. C. Huffman, Buckhannon; Charles L. Leonard, Elkins; Kenneth G. MacDonald, Charleston; and I. Ewen Taylor, Huntington.

Rehabilitation

J. C. Pickett, Morgantown, Chairman; C. B. Buffington, Wheeling; J. Marshall Carter, Huntington; Jean P. Cavender, Charleston; James A. Heckman, Huntington; Harold H. Kuhn, Charleston; Thomas H. McGavack, Martinsburg; Buford W. McNeer, Hinton; and Ralph H. Nestmann, Charleston.

Rural Health

Martha Jane Coyner, Harrisville, Chairman; Andrew E. Amick, Lewisburg; J. C. Arnett, Rowlesburg; B. S. Brake, Clarksburg; Vernon L. Dyer, Petersburg; Earl L. Fisher, Gassaway; O. M. Harper, Clendenin; J. C. Huffman, Buckhannon; Guy R. Post, Fairmont; E. Burl Randolph, Clarksburg; Clark K. Sleeth, Morgantown; and Charles E. Staats, Charleston.

Syphilis

N. H. Dyer, Charleston, Chairman; Ross O. Bell, Jr., and Paul V. Graham, Wheeling; Paul L. McCuskey, Parkersburg; C. Y. Moser, Kingwood; A. L. Osterman, Wheeling; Frank M. Peck, Huntington; Thomas L. Thomas, Wheeling; and Lyle D. Vincent, Parkersburg.

Tuberculosis

William L. Cooke, Charleston, Chairman; Charles E. Andrews, Morgantown; William B. Blake, Jr., Huntington; Oliver H. Brundage, Parkersburg; J. Russell Cook, Huntington; N. Allen Dyer, Bluefield; George F. Evans, Clarksburg; Ralph H. Nestmann and James H. Walker, Charleston; Paul P. Warden, Grafton; and M. L. White, Jr., Huntington.

SPECIAL COMMITTEES

AMA-ERF

Buford W. McNeer, Hinton, Chairman; Kenneth J. Allen, Moundsville; W. D. Bourn, Barboursville; C. Leonard Brown, Pt. Pleasant; Dante Castrodale, Welch; Harry F. Cooper, Beckley; John E. Echols, Richwood; Robert J. Fleming, Morgantown; Weldon Harloe, Princeton; I. M. Kruger, Logan; Karl J. Myers, Philippi; John F. Otto, Jr., Huntington; Earl S. Phillips, Wheeling; J. Keith Pickens, Clarksburg; C. D. Pruett, Bluefield; and Jack D. Woodrum, Hinton.

Medical-Dental Liaison

Ray M. Bobbitt, Huntington, Chairman; A. Morgan Dearman, Parkersburg; Edgar F. Heiskell, Jr., Morgantown; Clyde Litton and Newman H. Newhouse, Charleston; Kathryn P. Noble, Huntington; and Robert S. Robins, Wheeling.

Nurses Liaison

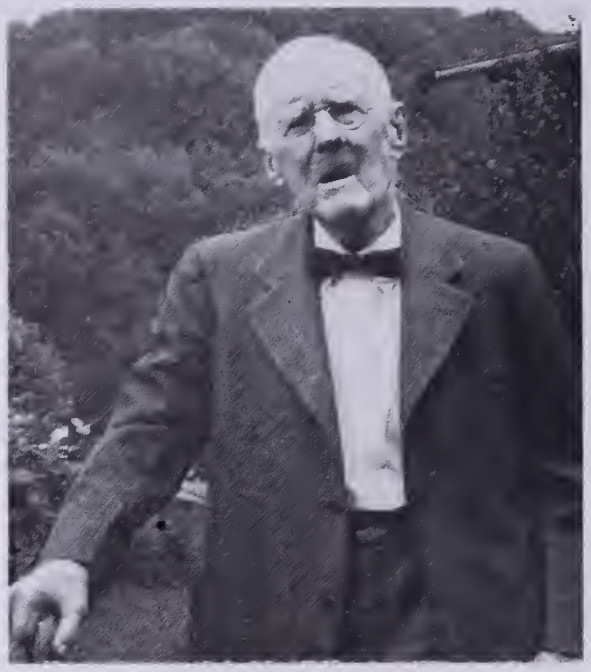
W. Fred Richmond, Beckley, Chairman; Vernon L. Dyer, Petersburg; C. A. Hoffman, Huntington; William A. Thornhill, Jr., Charleston; Edward J. Van Liere, Morgantown; A. J. Villani, Welch; and Walter R. Wilkinson, Huntington.

School Health

Leo H. Mynes, Charleston, Chairman; William M. Bruch, Bluefield; Donald M. Burke, Elkins; Thomas G. Folsom, Huntington; Emma Jane Freeman, Charleston; Grover C. Hedrick, Jr., Beckley; A. M. Jones, Parkersburg; Warren D. Leslie, Wheeling; M. Bruce Martin, Huntington; and Lyle D. Vincent, Parkersburg.

WVU Liaison

Thomas L. Harris, Parkersburg, Chairman; George F. Evans, Clarksburg; John A. B. Holt, Charleston; J. C. Huffman, Buckhannon; Nime K. Joseph, Wheeling; T. Kerr Laird, Montgomery; Jack Leckie, Huntington; J. P. McMullen, Wellsburg; Maynard P. Pride, Morgantown; Wade H. St. Clair and W. Hampton St. Clair, Jr., Bluefield.



Dr. James L. Cunningham

Dr. James L. Cunningham Celebrates 101st Birthday at Pickens Home

Dr. James L. Cunningham, who served for more than half a century as the family physician for the Pickens-Helvetia-Hacker Valley area, celebrated his 101st birthday on September 1.

Several friends gathered at his Pickens home to mark the occasion. Doctor Cunningham received numerous letters and cards from many sections of the United States—all from his "children."

He is quite proud of his "family." In his 64 years of practice, he delivered 3,600 babies in the mountainous area and never lost a mother.

Doctor Cunningham was born on September 1, 1863, just two months after West Virginia became the 35th State on June 20, 1863.

He and several others persons who reached their 100th year during 1963 were honored by Governor W. W. Barron for their contribution to West Virginia.

A native of Pittsburgh who spent his school days in Bridgeport, Ohio, Doctor Cunningham moved to West Virginia at the age of 18. He taught school for seven years and in 1888 enrolled in the Baltimore University Medical College. He returned to the Hacker Valley area in 1891 to set up a practice he continued until his retirement several years ago.

Although a recent survey by the American Medical Association disclosed that Doctor Cunningham is one of the nation's oldest living physicians, he doesn't have old ideas.

Last year he decided to participate in a Sabin Oral vaccine clinic held in the area.

"I don't want to die of polio after living all these years," he told the attending physician, "and I don't want to be a carrier, either."

Doctor Cooke To Be Honored By TB and Health Assn.

The West Virginia Tuberculosis and Health Association will hold its 44th Annual Meeting at The Stonewall Jackson Hotel in Clarksburg, October 7-8.

Dr. William L. Cooke of Charleston, President of the National Tuberculosis Association, will be the honor guest and will be the speaker at a banquet on Wednesday evening, October 7. His subject will be "The Need For the National Tuberculosis Association—A Voluntary Health Agency."

A reception honoring Dr. and Mrs. Cooke will be held at the home of Dr. and Mrs. George F. Evans on Wednesday afternoon, October 7.

On Wednesday afternoon, Dr. Charles E. Andrews, Professor of Medicine at the WVU School of Medicine, will serve as moderator of a panel discussion on "The Possibilities in Control of Eradication of Tuberculosis." Other participants will be Dr. Ernest W. Chick, Associate Professor of Medicine at the WVU School of Medicine, and Mr. James G. Stone of New York City, Executive Secretary of the NTA.

Medical Aspects of Sports Meeting Planned in Miami Beach

The Sixth National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of the AMA Committee on the Medical Aspects of Sports, will be held at the Deauville Hotel in Miami Beach, Florida, on November 29. The Conference will be held in conjunction with the AMA's annual Clinical Meeting in Miami Beach, November 29-December 2.

The Conference will cover a wide range of subjects. Included will be papers, panels and discussions relating to training and conditioning, prevention and treatment of injuries, physiology of sports participation, and other subjects.

Further information may be obtained by writing to the Secretary, Committee on the Medical Aspects of of Sports, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

O. D. Wyatt New Executive Director Of W. Va. Heart Association

Mr. O. D. Wyatt of South Charleston has been named Executive Director of the West Virginia Heart Association. He succeeds Mr. Robert M. Simons who has assumed a similar position with the Iowa Heart Association.

Mr. Wyatt is a native of Weirton and attended public schools in Hancock and Brooke Counties. He was graduated from the West Virginia University School of Journalism in 1956.

He served as City Editor of the Hinton Daily News for five years before joining the Heart Association as Public Relations Director in 1961.

Sections and Affiliated Societies Elect Officers for 1964-65

Meetings of sections and affiliated societies and associations of the West Virginia State Medical Association were held during the 97th Annual Meeting at The Greenbrier, August 20-22.

All of the guest speakers on the general scientific program participated actively in the afternoon meetings. The meetings were well attended, especially those for which a scientific program had been arranged.

Sections

Orthopedic Surgery: Robert S. Wilson, Clarksburg, President; Carl J. Roncaglione, Charleston, Vice President; and Thomas F. Scott, Huntington, Secretary-Treasurer.

W. Va. Radiological Society: Joseph L. Curry, Wheeling, President; E. Walter Rice, Martinsburg, Vice President; and Karl J. Myers, Philippi, Secretary-Treasurer.

W. Va. Association of Pathologists: Grover B. Swoyer, Charleston, President; Robert A. McDougal, Parkersburg, Vice President; and David F. Bell, Jr., Bluefield, Secretary-Treasurer.

W. Va. Academy of Oph. and Otol.: R. Alan Fawcett, Wheeling, President; Ralph W. Ryan, Morgantown, President Elect; Worthy W. McKinney, Beckley, Secretary-Treasurer; and J. E. Blaydes, Jr., Bluefield, Assistant Secretary-Treasurer.

Neurology, Neurosurgery and Psychiatry: Carrel M. Caudill, Charleston, President; W. E. Wilkinson, Beckley, President Elect; Curtis L. Withrow, Charleston, Secretary-Treasurer.

Surgery: William E. Gilmore, Parkersburg, President.

Internal Medicine: Arnold J. Brody, White Sulphur Springs, President; and E. L. Crumpacker, White Sulphur Springs, Secretary-Treasurer.

Urology: D. Franklin Milam, Morgantown, President; Harold N. Kagan, Huntington, Vice President; and James W. Lane, Charleston, Secretary-Treasurer.

W. Va. Pediatric Society: Russell V. Lucas, Jr., Morgantown, President; Emma Jane Freeman, Charleston, Vice President; and Meryleen B. Smith, Peterstown, Secretary-Treasurer.

Societies

W. Va. State Society of Allergy: Myer Bogarad, Weirton, President; Marshall J. Carper, Charleston, Vice President; and Merle S. Scherr, Charleston, Secretary-Treasurer.

W. Va. Society of Anesthesiologists: W. H. Rardin, Beckley, President; Newman H. Newhouse, Charleston, Vice President; and Jerill D. Cavender, Charleston, Secretary-Treasurer.

W. Va. Ob. and Gyn. Society: Dwight P. Cruikshank, Parkersburg, President; Daniel A. Mairs, Charleston, Vice President; and A. J. Villani, Welch, Secretary-Treasurer.

W. Va. Society of Internal Medicine: A. B. Curry Ellison, Charleston, President; James H. Getzen, Charleston, Secretary-Treasurer.

Dr. Seigle W. Parks of Fairmont, right, presents the championship golf trophy to Dr. Joseph T. Mallamo of Fairmont, winner of the medical golf tournament held in connection with the annual meeting at The Greenbrier.

Dr. Joseph T. Mallamo of Fairmont Wins Medical Golf Tourney

Dr. Joseph T. Mallamo of Fairmont won the medical golf tournament held in connection with the 97th Annual Meeting of the State Medical Association at The Greenbrier in White Sulphur Springs, August 20-22.

Doctor Mallamo shot a 71 to win his seventh title and a second leg on the beautiful trophy offered by the Hospital and Physicians Supply Company of Charleston.

A physician can retire the trophy with three tournament victories. Doctor Mallamo retired a previous trophy in 1960.

Dr. R. R. Brown of Romney, the defending champion, finished one stroke off the pace with a 72.

Other low gross scorers were Drs. Joseph A. Smith of Dunbar, 76; Joseph H. Selman of Charleston, 77; and Jack Leckie of Huntington, William C. Morgan, Jr., of Charleston, and George A. Curry of Morgantown, 80.

Dr. Robert A. Crawford, Jr., of Charleston took low net honors. Other winners in this category were Drs. William E. Gilmore of Parkersburg, R. R. Summers of Charleston, Kenneth E. Owen of Marietta, Ohio, William P. Bradford of Moundsville, L. Dale Simmons of Clarksburg, and George R. Callender, Jr., of Charleston.

The low gross winners were determined first. With a limit of one prize to a contestant, the low net winners were then figured from the remaining entrants using the Calloway Handicap System. There were several ties in both categories and the order of finish was figured by reusing their scores in a sudden death playoff.

The prizes were awarded at the reception honoring officers of the State Medical Association on Saturday evening, August 22.

Dr. Joseph A. Smith of Dunbar served as chairman of the golf committee and has been named by the president, Dr. Albert C. Esposito of Huntington, to serve again in 1965.

Ninth Annual Postgraduate Institute At Martinsburg, October 23-25

Thirty-two prominent physicians and scientists and one lay speaker will appear on the program for the Ninth Annual Potomac-Shenandoah Valley Postgraduate Institute in Martinsburg, October 23-25.

The three-day meeting is sponsored jointly by the Potomac-Shenandoah Valley PG Institute and the West Virginia Chapter of the American Academy of General Practice. Members of the American Academy of General Practice will be granted 18½ hours of credit for attendance at the meeting.

Juliet Lowell, author of 11 best sellers, will be the guest speaker at the Saturday evening banquet at the Shenandoah Hotel. Among her most successful books have been Dear Sir, Dear Mr. Congressman, Dear VIP and Dear Doctor.

Dr. Klaus Thomas of West Berlin will be the speaker at a dinner meeting on Friday. Doctor Thomas, visiting psychiatrist at St. Elizabeth's Hospital in Washington, D. C., will speak on "Berlin Today."

He is a former Lutheran pastor and also served as a hospital chaplain, medical doctor and psychologist in his native Germany. He currently is director of Berlin's clinic for the "Tired of Living."

Dr. Halvard Wanger of Shepherdstown, the Executive Director, said scientific and industrial exhibits will be housed in the Shenandoah Hotel and the scientific sessions will be held in the Apollo Theater.

Friday Morning Session

The first scientific session will be held on Friday morning, October 23, with the first hour devoted to basic science and the remainder to pediatrics. A panel discussion will follow the pediatrics program.

The speakers and their subjects will be as follows:

"Blood Volume Problems in the Newborn."—Doris A. Howell, M. D., Professor and Head of the Department of Pediatrics, Woman's Medical College of Pennsylvania, Philadelphia.

"The Effects of Reserpine Therapy on The Response to Sympathominetics."—William W. Fleming, Jr., Ph. D., Assistant Professor of Pharmacology, West Virginia University School of Medicine.

"Recent Advances in Diabetes."—Samuel Bessman, M. D., Associate Professor of Biochemistry and Professor of Pediatric Research at the University of Maryland School of Medicine.

"Recent Advances in the Care of Premature Babies."—Richard L. Day, M. D., Professor and Chairman of Pediatrics, University of Pittsburgh School of Medicine.

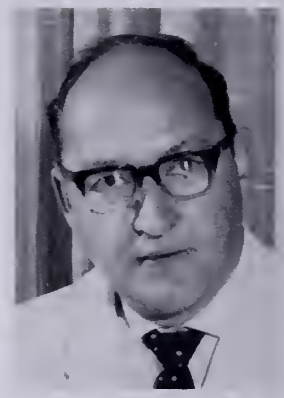
"Diagnosis of the Bleeding Child."—Doris A. Howell, M. D.

"Radiographic Aspects of Newborn Surgical Emergencies."—Joseph M. LoPresti, M. D., Associate Clinical Professor of Radiology at Georgetown University School of Medicine and George Washington University School of Medicine, Washington, D. C.

Afternoon Session

There will be a round table discussion at the Friday luncheon and the discussion leader at each table of eight will be a speaker or other authority.

Juliet Lowell



Klaus Thomas Th.D., M. D.

The afternoon session on Friday will be devoted to Medicine. The speakers and their subjects are as follows:

"Steroid Therapy of Arthritis."—Thomas H. McGavack, M. D., Martinsburg, Clinical Professor Emeritus, New York Medical College.

"Gout—Diagnosis and Management."—John W. Sigler, M. D., Director, Arthritis Clinic, Henry Ford Hospital, Detroit.

"Petit Mal Epilepsy—Diagnosis, Treatment and Prognosis."—Samuel Livingston, M. D., Assistant Professor and Director of Epilepsy Clinic, Johns Hopkins University School of Medicine, Baltimore.

"Long Term Planning in Chronic Disease."—Count D. Gibson, Jr., M. D., Professor and Head of Preventative Medicine, Tufts University School of Medicine, Boston.

Dr. Klaus Thomas Dinner Speaker

Dr. Klaus Thomas, visiting psychiatrist at St. Elizabeth's Hospital in Washington, D. C., will be the speaker at the dinner on Friday. His subject will be "Berlin Today."

Saturday Morning Program

The Saturday morning session will be devoted to medicine following the first hour of basic science from 8 to 9 A. M. The program is as follows:

"A Few Clinical Misconceptions Revealed by Autopsy Studies."—Harlan I. Firminger, M. D., Professor and Head of the Department of Pathology, University of Maryland School of Medicine.

"Physical Diagnosis."—Louis Krause, M. D., Professor of Medicine, University of Maryland School of Medicine.

"Understanding and Management of the Chronically Ill and the Dying Patient."—Paul E. Chodoff, M. D., Assistant Professor of Psychiatry, George Washington University School of Medicine.

"The Human Pylorus and Idiopathic Hypertrophy."—Charles M. Thompson, M. D., Professor and Head, Department of Gastroenterology, Hahnemann Medical College, Philadelphia.

"The Significance of Intellectual Deterioration."—Charles Van Buskirk, M. D., Clinical Professor of Neurology, University of Maryland School of Medicine.

Afternoon Session

The following program on Medicine will be presented on Saturday afternoon:

"Suicide."—Klaus Thomas, Th. D., M. D., Visiting Psychiatrist, St. Elizabeth's Hospital, Washington, D. C.

"Diagnosis by Sight."—Perry S. MacNeal, M. D., Associate Professor of Clinical Medicine, University of Pennsylvania School of Medicine.

"Anxiety and the Minor Tranquilizers After 10 Years."—John C. Krantz, Jr., Ph. D., Professor and Head of Pharmacology, University of Maryland School of Medicine.

"Transfusion Problems."—Julius R. Krevans, M. D., Associate Professor of Medicine, Johns Hopkins University School of Medicine.

Banquet Saturday Evening

A reception will be held Saturday evening from 6 to 6:30 P. M. followed by the annual banquet. Authoress Juliet Lowell will be the guest speaker at the banquet and her subject will be "It Strikes Me Funny."

Physicians and their wives are invited to attend a dance that evening. Music will be furnished by Russ Lang's Orchestra of Washington.

Sunday Morning Session

The Sunday morning session will be devoted to Obstetrics and Gynecology after the first hour of basic science. The program is as follows:

"Anatomical Explanation of Cranial Nerve Signs Occurring with Tumors Near the Base of the Skull."—Robert J. Johnson, M. D., Professor and Chairman, Department of Anatomy, University of Pennsylvania Graduate School of Medicine, Philadelphia.

"Anatomical Explanation of Neurological Lesions Causing Bladder Dysfunction."—Robert J. Johnson, M. D.

"Oral Contraception—Recent Advances."—Alvin F. Goldfarb, M. D., Assistant Professor of Obstetrics and Gynecology, Jefferson Medical College, Philadelphia.

"Evaluation of the Uterine Cervix."—Warren R. Lang, M. D., Professor of Obstetrics and Gynecology, Jefferson Medical College.

"Genetics in Obstetrics and Gynecology."—James S. Sites, M. D., Associate Professor of Obstetrics and Gynecology, George Washington University School of Medicine.

"Breech Presentation and Delivery."—Philip P. Steptoe, M. D., Associate Professor of Obstetrics and Gynecology, Georgetown University School of Medicine.

Address by Dr. Perry S. MacNeal

Dr. Perry S. MacNeal, Associate Professor of Clinical Medicine at the University of Pennsylvania School of Medicine, will address the Sunday luncheon session. His subject will be "Who is YOUR Doctor?"

The Sunday afternoon session on surgery, beginning at 2:15 P. M., is as follows:

"The Esophageal-Hiatus Hernia."—Jacob C. Handelsman, M. D., Associate Professor of Surgery, Johns Hopkins School of Medicine.

"Clinical Management of Refractory Shock."—Arlie R. Mansberger, M. D., Associate Professor of Surgery, University of Maryland School of Medicine.

John C. Krantz, Jr., Ph. D.

Perry S. MacNeal, M. D.

"The Etiology and Medical Management of Urinary Calculi."—John D. Young, M. D., Head of the Division of Urological Surgery, University of Maryland School of Medicine.

Another attraction available during the meeting is the Shenandoah Downs race track at Charles Town on Friday and Saturday nights.

The registration fee is $25 for the entire three-day course and $10 for a single day. Further information may be obtained by writing to Halvard Wanger, M. D., Executive Director, Box 175, Shepherdstown, West Virginia.

Scholarships Awarded 11 Students By W. Va. Nurses Association

Eleven student nurses recently received scholarships for the year 1964-65 through a program sponsored by the West Virginia Nurses Association. Announcement of the grants was made by Mr. H. P. Porter of Charleston, chairman of the West Virginia Professional Nursing Education Trust, and Mrs. Josephine Fultz of Clarksburg, president of the sponsoring organization.

Six of the scholarships are new and five are renewed grants to students enrolled in state-accredited schools of nursing. New grants were awarded to the enrolling schools for the following students:

Sandra Jeanne Henderson of Clay, junior at Charleston General Hospital of Nursing, Charleston; Linda Sue Holdren of Webster Springs, sophomore at Alderson-Broaddus College, Philippi; Sally Ann Lynch of Clarksburg, freshman at St. Mary's School of Nursing, Clarksburg; Mrs. Carol McCauley Montoya of Elizabeth, junior at West Virginia Wesleyan College, Buckhannon; Sharon Jane Shreve of Fairmont, freshman at St. Mary's School of Nursing, Clarksburg; and Carol Ann Williams of Charleston, freshman at Charleston General Hospital School of Nursing, Charleston.

Scholarship grants were renewed for Sharon Elizabeth Herbach at Davis Memorial Hospital, Elkins; Sandra Jean Kacinec at St. Mary's Hospital, Clarksburg; Mary Wilodene Paugh at Alderson-Broaddus College; Mrs. Jane Davis Pruett at West Virginia Wesleyan College; and Alice Vint at Camden-Clark Hospital in Parkersburg.

Mrs. George A. Curry of Morgantown New Auxiliary President

Mrs. George A. Curry of Morgantown was installed as President of the Woman's Auxiliary to the West Virginia State Medical Association during the 40th Annual Meeting at The Greenbrier in White Sulphur Springs, August 20-22. She succeeds Mrs. Pat A. Tuckwiller of Charleston.

Nearly 140 wives of physicians were registered during the three-day meeting which was held concurrently with the 97th Annual Meeting of the West Virginia State Medical Association.

Mrs. George A. Curry

Mrs. Curry and other new officers were installed at the second general session on Friday morning, August 21, by Mrs. William H. Evans of Youngstown, Ohio, president of the Woman's Auxiliary to the American Medical Association. Mrs. Evans also delivered the keynote address at the opening session on Thursday morning.

Inaugural Address

Mrs. Curry delivered her inaugural address on Friday morning. She cited the continuous growth of the Auxiliary's contributions to AMA-ERF with the total reaching nearly $2 million since 1951.

"To keep this and all our services alive and growing, we need active members with humility, generosity, compassion, the capacity for clear thinking, a clear understanding of what freedom means, and a deep and abiding faith in God," she declared.

"In my opinion, the Auxiliary is not an isolated portion of our lives. As we develop into good members, we become better citizens, better wives and parents, and better church members. Although we work to promote health measures and health education, Auxiliary objectives are compatible with the basic values in which we believe. We, like our doctor husbands, are motivated by a sincere concern for humanity."

Auxiliary members joined their husbands and families in Governor's Hall for the Association's opening exercises on Thursday morning. The first speaker was Dr. Perry E. Gresham, President of Bethany College.

Mrs. Wilson P. Smith of Huntington was named president elect and will be installed as president during the 1965 annual meeting at The Greenbrier next August. Other new officers for the coming year are as follows:

First vice president, Mrs. Herbert N. Shanes of Grafton; second vice president, Mrs. C. J. Holley of Wheeling; third vice president, Mrs. J. A. B. Holt of Charleston; fourth vice president, Mrs. Ray M. Kessel of Logan; treasurer, Mrs. J. Dennis Kugel of Charleston; recording secretary, Mrs. Robert J. Tchou of Williamson; corresponding secretary, Mrs. Maynard P. Pride of Morgantown; and parliamentarian, Mrs. William R. Rice of Dunbar.

Committees

Archives and History, Mrs. Charles L. Goodhand of Parkersburg; Finance, Mrs. Harry E. Beard, Huntington; By-Laws and Handbook, Mrs. William A. Thornhill, Jr., Charleston; Editor, State News Bulletin, Mrs. W. M. Warman, Morgantown; Circulation Manager, News Bulletin, Mrs. James Hugh Wiley, Morgantown: Southern Medical Councilor, Mrs. Ross P. Daniel, Beckley; and Necrology, Mrs. Robert R. Pittman, Marlinton.

Convention, Mrs. Clark K. Sleeth and Mrs. Robert J. Fleming, Morgantown; Liaison to Woman's Auxiliary, Student American Medical Association, Mrs. Clark K. Sleeth, Morgantown; Program, Mrs. Harry S. Weeks, Jr., Wheeling; Membership, Mrs. Wilson P. Smith, Huntington; Members-at-Large, Mrs. Buford W. McNeer, Hinton; Legislation, Mrs. L. Dale Simmons, Clarksburg; and American Medical Association Education and Research Foundation, Mrs. Joe N. Jarrett, Oak Hill.

Press and Publicity, Mrs. Rupert W. Powell, Fairmont; National Bulletin, Mrs. C. S. Harrison, Clarksburg; Community Service and International Health Activities, Mrs. A. C. Chandler, Charleston; Disaster Preparedness and Safety, Mrs. Lysle T. Veach, Petersburg; Health Careers, Mrs. Charles H. Hiles, Wheeling; Mental Health, Mrs. John W. Hash, Charleston; and Rural Health and Nutrition, Mrs. Lynwood D. Zinn, Clarksburg.

Executive Board

Two past presidents of the Auxiliary, Mrs. Howard G. Weiler of Wheeling and Mrs. Pat A. Tuckwiler of Charleston have been appointed by Mrs. Curry to serve as members of the Executive Board.

Advisory Board

Dr. Albert C. Esposito of Huntington, President of the West Virginia State Medical Association, has named the following Advisory Board to the Woman's Auxiliary:

Dr. Clark K. Sleeth, Morgantown, Chairman; Dr. D. E. Greenelteh, Wheeling; Dr. Martha J. Coyner, Harrisville; Dr. Joe N. Jarrett, Oak Hill; and Dr. George A. Curry, Morgantown.

New President Native West Virginian

Mrs. George A. Curry, the new president, is a native of Fairview, Marion County, and was graduated from West Virginia University where she was active in various campus organizations.

Dr. and Mrs. Curry have four children. George is a freshman at Yale University, Cathy is a senior at Morgantown High School, Carol is a third grader and Christopher is five years of age.

Mrs. Curry was a charter member of the Woman's Auxiliary to the Monongalia County Medical Society and was its first vice president. She has been active for many years in the State Auxiliary and she has served as AMA-ERF Chairman, program chairman, legislative chairman, treasurer, vice president on two occasions, and president elect.

Post-Convention Conference

Mrs. Curry presided at the post-convention conference and meeting of the Executive Board on Saturday morning, August 22, at which time plans for the coming year were discussed.

Dr. Albert C. Esposito, who was installed as President of the State Medical Association during the Annual Meeting, attended the session and spoke briefly.

He thanked the members of the Auxiliary for their splendid cooperation during the past year and asked for continued support during his term of office.

Fall Conference

The annual Fall Conference and Director's Board Meeting of the Woman's Auxiliary to the West Virginia State Medical Association will be held at the Beckley Hotel in Beckley, October 20-21.

The conference will begin at 3:30 P. M. on Tuesday, October 20 and the Board Meeting will open at 9:30 A. M. on Wednesday, October 21.

Mrs. George A. Curry of Morgantown, who was installed as President of the State Auxiliary at The Greenbrier in August, has issued an invitation to all directors and presidents of county auxiliaries to attend the two-day session.

Entertainment Program

A capacity crowd attended the 40th Anniversary Ball which was held in Chesapeake Hall on Friday evening, August 21.

Program Committees

Mrs. J. A. B Holt and Mrs. A. B. Curry Ellison, both of Charleston, served as convention co-chairmen. Mrs. Curry has appointed Mrs. Clark K. Sleeth and Mrs. Robert J. Fleming of Morgantown, as co-chairmen of the 1965 convention.

Mrs. Gilmore Golf Winner

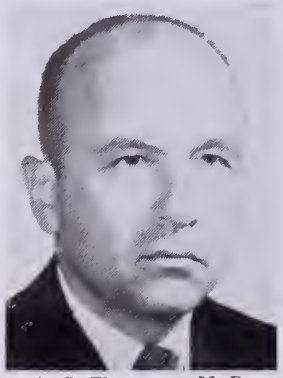
Mrs. William E. Gilmore of Parkersburg won the annual golf tournament for the third consecutive year. Her closest rival for the low gross was Mrs. W. E. McNamara of Wheeling.

Mrs. Pat A. Tuckwiller of Charleston, left, immediate past president of the Woman's Auxiliary to the West Virginia State Medical Association, is shown with Mrs. William H Evans of Youngstown, Ohio, President of the Woman's Auxiliary to the American Medical Association. In the other photo are new officers elected at the Auxiliary's 40th Annual Meeting at The Greenbrier. Front row, left to right,

Mrs. J. Dennis Kugel of Charleston, treasurer; Mrs. George A. Curry, Morgantown, president; and Mrs. Robert J. Tchou, Williamson, recording secretary. Second row, Mrs. J. A. B. Holt, Charleston, third vice president; Mrs. William R. Rice, Dunbar, parliamentarian; and Mrs. Wilson P. Smith, Huntington, president elect.

Dr. A. C. Thompson New President Of W. Va. Heart Association

Dr. A. C. Thompson of Elkins was installed as president of the West Virginia Heart Association at the annual meeting held at the UpTowner Inn in Huntington, September 3-4. He succeeds Dr. Otis G. King of Bluefield.



A. C. Thompson, M. D.

Other officers elected were as follows:

Dr. Albert D. Kistin of Beckley, president elect; Dr. Herbert E. Warden of Morgantown, vice president; Mrs. F. Tyler Easley of Bluefield, secretary; and Miss Mary Helen Thompson of Charleston, treasurer.

Fourteen new members were named to the Association's 70-member Board of Directors. They are as follows:

Garland Frasher, Harry Dunfee and Mrs. Betty McLaughlin of Huntington; Dr. P. J. Corbitt, Rolla McDougle and Thomas N. Webster of Parkersburg; Mrs. Mabel Grimes, Dr. Roland Schmidt and Mrs. Gloria Whieldon of Morgantown; Mrs. Linda Gibson of Hurricane; Mrs. Wendell Fultz of Clarksburg; Dr. Ernest G. Guy of Philippi; Granville Shirley of Martinsburg and Jack H. Smith of Fairmont.

Second Fall Meeting of ACP Planned In Los Angeles, Oct. 8-10

The Second Fall Meeting of the American College of Physicians will be held at the Biltmore Hotel in Los Angeles, October 8-10.

In addition to the usual clinical papers, a basic science lecture will be presented at the end of each afternoon session for consideration of the basic medical subjects.

Dr. Robert U. Drinkard, Jr., of Wheeling, is a member of the ACP Board of Governors.

Program Committee for 1965

Dr. Richard J. Stevens of Huntington has been named by Dr. Albert C. Esposito of Huntington, President of the State Medical Association, as chairman of the committee which will arrange the program for the 98th Annual Meeting at The Greenbrier in White Sulphur Springs, August 26-28, 1965.

The other members of the committee are Drs. Richard W. Corbitt of Parkersburg, Jack Leckie of Huntington, Kenneth G. MacDonald of Charleston, and Maynard P. Pride and Clark K. Sleeth of Morgantown.

Health Officials Stress Importance Of Vector Control Programs

Arthropod-borne encephalitis has not been a problem in West Virginia, nor is it expected to be. But because of national attention on the epidemic of St. Louis encephalitis in Houston, Texas, and the fact that the encephalitis-carrying mosquito has been isolated and identified in West Virginia, it is important for state health personnel to be aware of the potential dangers and foster vector control programs.

In the weekly State of the State's Health, State Health Director Dr. N. H. Dyer said that West Virginia does not necessarily fall within any one of the geographical areas usually associated with the three types of encephalitis most frequently found in the United States.

Eastern equine encephalitis is confined mainly to the Atlantic and Gulf coasts and inland along the Mississippi River Valley. Western equine encephalitis occurs most often in states west of the Mississippi and in Wisconsin and Illinois. St. Louis encephalitis is found in all states west of the Mississippi and along the Ohio River Valley.

With the exception of three years, West Virginia has had reported cases of encephalitis since 1933. None of these cases, however, has been identified as arthropod-borne although the mosquito, the culex pipiens-quinquefasciatus complex, was identified in August, 1958, during a vector control survey in the Huntington area.

Doctor Dyer indicated that the Houston epidemic should point out the continuing need for awareness of environmental sanitation. Health officials should be alerted to the potential dangers whenever there is a breakdown in the barriers that environmental sanitarians have sought to construct and be reminded that environmental problems, by their very nature, must continue to be a major part of any public health program.

Immunization Program Planned

The immunization campaign, conducted under the Vaccination Assistance Act, will move into high gear in approximately one third of the state's counties during the next several months where preliminary sample surveys have been completed to determine the over-all picture of immunization levels.

Through forthcoming school surveys, immunization levels will be further defined to pinpoint pockets of susceptibles who have not been vaccinated or who have not received proper booster shots. Counties which have already been surveyed according to a random house-to-house selection include Mingo, Logan, Wyoming, McDowell, Mercer, Fayette, Cabell, Monongalia, Marion, Harrison, Preston, Randolph, Wetzel, Tyler, Kanawha, Summers, Lewis, Pocahontas, and Raleigh. Surveys are also planned in Barbour, Upshur, Gilmer, Mason, and Putnam counties.

New Association Members

Dr. R. J. Bailey, 1100 Market Street, Parkersburg (Parkersburg Academy). Doctor Bailey, a native of Bridgeport, attended the two-year WVU School of Medicine and received his M. D. degree in 1957 from the Medical College of Virginia. He interned at Mount Carmel Hospital in Columbus, 1957-58, and served a residency at the Medical College of Virginia Hospital, 1958-60. He served for three years in the Medical Corps of the U. S. Air Force in Japan, and was released in 1963 with the rank of Captain. His specialty is pediatrics.

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Dr. Asa Barnes, Box 1229, Beckley (Raleigh). Doctor Barnes, a native of Marston, Missouri, was graduated from the University of Missouri and received his M. D. degree in 1931 from the University of Tennessee College of Medicine. He interned at the U. S. Marine Hospital, Public Health Service, 1931-32, and received a M.P.H. degree in 1940 from the Johns Hopkins University School of Public Health. He served for nearly five years with the Medical Corps of the U. S. Army during World War II and he retired with the rank of Colonel following 39 years of active reserve duty. He was previously located in Louisville and he is currently serving as Area Medical Administrator for the UMWA.

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Dr. Alphonse C. Edmundowicz, WVU Medical Center, Morgantown (Monongalia). Doctor Edmundowicz was born in Nanticoke, Pennsylvania, and was graduated from Villanova University. He received his M. D. degree in 1955 from Hahnemann Medical College, and served an internship at Harrisburg General Hospital, 1955-56. He served as a Fellow in Internal Medicine and Cardiovascular Physiology at the Mayo Clinic Foundation, 1958-61, and he was certified by the American Board of Internal Medicine in 1962. He served as a Lieutenant in the Medical Corps of the U. S. Navy, 1956-58. He is currently serving as Assistant Professor of Medicine at the WVU School of Medicine.

Dr. Frederick D. Gillespie, 211 Eleventh Street, Parkersburg (Parkersburg Academy). Doctor Gillespie, a native of Yukon, McDowell County, was graduated from West Virginia University and received his M. D. degree in 1956 from the University of Virginia School of Medicine. He interned at the University of Iowa Hospital, 1956-57, and served a residency at the University of Alabama, 1959-62. He served in the U. S. Army, 1945-47, and was previously located in Birmingham. His specialty is ophthalmology.

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Dr. Ray R. Hagley, 2581 Third Avenue, Huntington (Cabell). Doctor Hagley, a native of Huntington, was graduated from Marshall University and received his M. D. degree in 1960 from the George Washington University School of Medicine. He interned at Marion County General Hospital in Indianapolis, 1960-61, and then served as a Lieutenant in the Medical Corps of the U. S. Navy. He is engaged in general practice.

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Dr. A. E. Harrington, The Golden Clinic, Elkins. (B-R-T). Doctor Harrington, a native of Ansonia, Connecticut, was graduated from Catholic University and received his M. D. degree in 1932 from Georgetown University School of Medicine. He interned at Danburg and Greenwich hospitals in Connecticut, 1932-33, and had postgraduate work at Harvard and the University of Illinois. He served as a Major in the Medical Corps of the U. S. Air Force, 1942-46, and was previously located in Lincoln, Nebraska. His specialty is EENT.

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Dr. Sherman E. Hatfield, 1112 Virginia Street, E., Charleston (Kanawha). Doctor Hatfield, a native of Simon, Wyoming County, was graduated from West Virginia University and received his M. D. degree in 1953 from the Medical College of Virginia. He interned at Charleston Memorial Hospital, 1958-59, and served residencies at that hospital and Baylor Affiliated Hospital in Houston, 1959-63. His specialty is otolaryngology.

Early visitors to the Exhibit Center were Dr. and Mrs. Pat A. Tuckwiller of Charleston, Mrs. Albert C. Esposito of Huntington, and Drs. J. C. Huffman and R. L. Chamberlain of Buckhannon. Mrs. Tuckwiller is the immediate past president of the Woman's Auxiliary to the State Medical Association. In the other photo, Dr. Anthony F. DePalma of Philadelphia, center, is shown with Drs. William H. Evans of Youngstown, and Carl J. Roncaglione of Charleston. Doctor DePalma was a guest speaker at the second general session.

Dr. Mehmet V. Kalaycioglu, 40 Main Street, Shinnston (Harrison). Doctor Kalaycioglu, a native of Ismir, Turkey, was graduated from the Faculty of Science in Istanbul and received his M. D. degree in 1950 from the University of Turkey Faculty of Medicine. He served as a Lieutenant in the Turkish Navy. He interned at St. Alexis Hospital in Cleveland, 1952-53, and served a residency at Broaddus Hospital in Philippi, 1954-57. He served a five-year residency in general surgery.

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Dr. Stephen T. J. Lee, Appalachian Regional Hospital, Beckley (Raleigh). Doctor Lee, a native of Hawaii, was graduated from Marquette University and received his M. D. degree in 1955 from the Marquette University School of Medicine. He interned at Charity Hospital in New Orleans, 1955-56, and served a residency at Beckley Memorial Hospital, 1959-63. He served as a Captain in the Medical Corps of the U. S. Army, 1957-59, and his specialty is general surgery.

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Dr. Russell V. Lucas, Jr., WVU Medical Center, Morgantown (Monongalia). Doctor Lucas, a native of Des Moines, Iowa, was graduated from Macalester College and received his M. D. degree in 1954 from the Washington University School of Medicine. He interned and served a residency at the University of Minnesota Hospital and he served as a Captain in the Medical Corps of the U. S. Army, 1956-58. He is currently serving as Assistant Professor of Pediatrics at the WVU School of Medicine.

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Dr. Henry J. Pitsenberger, 416 8th Street, Belle (Kanawha). Doctor Pitsenberger, a native of Runa, Nicholas County, was graduated from West Virginia University and received his M. D. degree in 1962 from the California College of Medicine. He interned at Los Angeles County General Hospital, 1962-63, and served for more than two years with the U. S. Air Force. He is engaged in general practice.

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Dr. Ramon Portales, Holden Hospital, Holden (Logan). Doctor Portales was born in Mexico and received his M. D. degree in 1955 from the Universidad Nacional Autonoma de Mexico. He interned at General Hospital in Mexico City and Memorial Hospital in Wilmington, Delaware, and served a residency at Kent General Hospital in Dover, Delaware. He was licensed to practice in West Virginia in 1963.

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Dr. H. Jackson Teets, Weirton General Hospital, Weirton (Hancock). Doctor Teets, a native of Montrose, Randolph County, was graduated from West Virginia University and received his M. D. degree in 1947 from Hahnemann Medical College. He interned at Hahnemann Hospital and served a residency at the University of Virginia Hospital. He served for three years in the U. S. Army and he previously was located in Chambersburg, Pennsylvania. His specialty is radiology.

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Dr. James P. Thomas, Bluefield Sanitarium Clinic, Bluefield (Mercer). Doctor Thomas, a native of Baltimore, was graduated from the University of North Carolina and received his M. D. degree in 1955 from the Johns Hopkins University School of Medicine. He interned at Johns Hopkins University Hospital, 1955-56, and served a residency at that hospital and at Bowman-Gray Hospital, 1956-63. He is certified by the American Board of Surgery. He served as a Major in the Medical Corps of the U. S. Air Force, 1957-59, and his specialty is general and thoracic surgery.

PG Course on Blood Banking

A postgraduate course on "Blood Banking" will be sponsored by the Cleveland Clinic Educational Foundation in Cleveland, October 28-29. The course will be co-sponsored by the Northern Ohio Red Cross Regional Blood Center.

The registration fee is $30 for the two-day course. Further information may be obtained by writing Dr. Walter J. Zeiter, Director of Education, The Cleveland Clinic Educational Foundation, 2020 East 93rd Street, Cleveland, Ohio, 44106.

Dr. Robert D. Crooks of Parkersburg, left, a member of the Program Committee, is shown with Dr. Waldo E. Nelson of Philadelphia, Professor and Head of the Department of Pediatrics at the Temple University School of Medicine. Doctor Nelson was a guest speaker at the second general session. In the other photo, Dr. John M. Howard, left, Professor of Surgery at Hahnemann Medical College in Philadelphia, is shown with Dr. William E. Gilmore of Parkersburg, Chairman of the Program Committee. Doctor Howard was a guest speaker at the first general session.

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atropine sulfate . . . . . 0.025 mg.

- lowers motility promptly
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Both experimental and clinical evidence indicates that Lomotil exerts such control efficiently, safely and with maximal promptness.

dosage:

The recommended initial *adult* dosage is two tablets (2.5 mg. each) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. *Children's* daily dosage (in divided doses) varies from 3 mg. for a child of 3 to 6 months, to 10 mg. for one 8 to 12 years of age.

cautions and side effects:

Lomotil is an exempt narcotic; its abuse liability is low and comparable to that of codeine. Recommended dosages should not be exceeded. Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates.

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SEARLE

Research in the Service of Medicine

WVU Medical Center
—News—

Arthur V. Ciervo of Weirton has been named director of the Medical Center News and Information Services at West Virginia University. He succeeds Mr. Howard Lewis, who has accepted a science writing fellowship at Columbia University. Mr. Lewis joined the Medical Center staff in 1962 after serving as a reporter and assistant political editor with the Charleston Daily Mail.

Arthur V. Ciervo

The new information director is a 1957 graduate of the West Virginia University School of Journalism and formerly served as an associate editor of the Weirton Steel Company's magazine, The Employees Bulletin.

Mr. Ciervo was formerly a reporter with the Brownsville, Pennsylvania, Telegraph and was a member of the Associated Press staffs in Philadelphia and Pittsburgh for two and one-half years before assuming his post at Weirton.

He is a native of Richeyville, Pennsylvania, and was active in community and civic affairs in Weirton. At the Medical Center he will work with the press, radio and television in explaining the purposes, practices and program at the center to the public. He will work directly under Dr. Kenneth E. Penrod, Vice President of WVU in charge of the Medical Center.

Hospital Provides 88,000 Days of Care

The WVU Hospital provided more than 88,000 days of care for patients in the fiscal year which ended on June 30, 1964.

A recent report disclosed that 85 to 90 per cent of the patients were West Virginians and most of the others came from nearby sections of Pennsylvania and Maryland.

Community physicians, who continue to be the key to development of the hospital, have referred more than 36,000 persons for diagnosis and treatment. The three busiest services are adult surgery, medicine and pediatrics, in that order.

In the 1963-64 fiscal year, 545 babies were born and 3,178 persons had major surgery for a variety of health problems. As a part of their diagnosis and treatment, patients received more than 30,000 diagnostic and 224,333 clinical laboratory procedures.

• **Compiled from material furnished by Arthur V. Ciervo, Director, Medical Center News and Information Services, Morgantown, West Virginia.**

The outpatient clinic recorded 34,627 individual visits for diagnostic and medical workups, and 14,278 persons came to the emergency room for care.

The WVU Hospital opened on August 10, 1960, and has been staging its beds into service so that 320 are now available. Additional beds will be commissioned before the end of the year.

Two Instructors Appointed

Dr. Carolyn J. Wilkinson, a native of Clarksburg, and Dr. Antonio Palladino, a native of Italy, have been named to the faculty of the WVU School of Medicine.

Doctor Wilkinson, whose specialty is anesthesiology, accepted appointment as an Instructor in Surgery. She is a 1953 graduate of Washington Irving High School in Clarksburg and received a Bachelor of Arts degree from Wellesley College. She received her M. D. degree from the Medical College of Virginia and served a residency in anesthesia at the University of Pennsylvania School of Medicine.

Doctor Palladino, who was named an Instructor in Obstetrics and Gynecology, attended schools in Italy and received his M. D. degree from the University of Napoli, Italy.

He served an internship and residency in obstetrics and gynecology at City Hospital in Baltimore, Maryland. He was later chief resident at University Hospital in Ottawa, Canada, and was a clinical research fellow at the McGill University Faculty of Medicine in Montreal. He recently completed three years duty with the Medical Corps of the United States Army.

Lecture on Renal Hypertension

Dr. A. E. Doyle of Melbourne, Australia, Professor of Medicine at the University of Melbourne Faculty of Medicine, will lecture on "Renal Hypertension" at the WVU Medical Center on November 16.

Doctor Doyle is visiting the United States to participate in a conference on high blood pressure sponsored by the American Heart Association.

He was invited to lecture at WVU by Dr. Robert J. Marshall, Professor of Medicine, who formerly worked with Doctor Doyle in Australia.

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The Month in Washington

PHYSICIAN ownership of pharmacies is ethical as long as the patient is not exploited, the American Medical Association told Congress. Robert B. Throckmorton, AMA general counsel, testified before the Senate Subcommittee on Antitrust and Monopoly that:

"The ownership of a pharmacy by a physician cannot in itself be equated with exploitation. The confidence and trust that the patient reposes in his doctor—to use his knowledge, his skill, his judgment in prescribing medicines, and his understanding of the patient's financial problems—preclude a blanket charge of physician-pharmacy-exploitation.

"It would be a disservice to the public and to the medical profession if from these hearings there issued the unwarranted impression that physicians could not be trusted to own pharmacies or to carry on their professional practices in other more important respects without exploiting their patients. It would be unfortunate . . . if a small incidence of violations and alleged violations came to be accepted as 'proof' of widespread unethical practices."

Throckmorton pointed out that both the AMA House of Delegates and the AMA Judicial Council had ruled that it is not wrong, per se, for a physician to have a financial interest in a pharmacy. However, he added, the AMA House of Delegates last year adopted flat prohibitions against physician ownership in a drug repackaging company or controlling interest in a pharmaceutical company while engaged in the practice of medicine. He said that there were relatively few cases of such ownership.

Throckmorton said that less than two per cent of the nation's 280,000 physicians have any financial interest in drug repackaging companies.

"Most physicians who acquired financial interests in repackaging firms prior to the AMA statement of policy acted in good faith," he said. "Unless they were a part of the tattered fringe of practitioners who intended to exploit their patients, they had no reason to believe that they were engaging in any unethical act. Many of these physicians who still retain their ownership can, at the most, be censored only for 'good faith misbehavior'. However, any continued ownership, beyond a reasonable period of time to permit severance without undue hardship, should call for the institution of prompt disciplinary action within the ranks of medicine."

Congressional prospects brightened for legislation exempting community and other non-profit blood banks from the antitrust laws.

• **From the Washington Office of the American Medical Association.**

The chief counsel of the Senate Antitrust and Monopoly Subcommittee, Bernard Finsterwald, Jr., said he believed Congress eventually would approve this legislation, backed by the AMA.

The bill was introduced by Sen. Edward Long (D., Mo.) after a Federal Trade Commissioner examiner ruled that community blood banks are subject to antitrust law and charged the Kansas City area community blood bank with restraint of trade by refusing to purchase blood from commercial, profit firms.

Dr. Gunnar Gundersen, chairman of the AMA Blood Bank Committee and a past president of AMA, told the Senate subcommittee that:

"The AMA views with great concern the recent decision of the hearing examiner of the Federal Trade Commission finding that human whole blood is a commodity or article of commerce and as such is subject to 'trade' and 'commerce' within the meaning of those terms as used in the Federal Trade Commission Act. The import of this decision is fraught with many dangers and creates serious problems for the physician. Based upon this decision, the physician's and hospital's freedom of choice in selecting blood is severely restricted, lest they be deemed in restraint of trade.

Congress sent to the White House a record $1 billion budget for the National Institutes of Health. All told, the bill contained $6.5 billion for the HEW Department's activities during the current fiscal year.

The lawmakers provided $1 million for the long-delayed environmental health center but specified that it be located no closer than 50 miles from the Washington, D. C. area. The Administration sought to have the center located in the Washington suburbs at Beltsville, Maryland.

Congress approved $222.6 million for the Hill-Burton program of Federal aid for hospital construction, $110.8 million for Federal aid to medical education, and $8 million for tuberculosis control activities.

As the measure finally cleared Congress, the HEW total was $603 million less than the Administration requested, but $942 million more than the House had originally voted.

A five-year, $283 million program of federal aid to spur the training of nurses also was signed into law by President Johnson.

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Annual Reports*

Insurance Committee

It is with the deep personal pride of every member of the Insurance Committee that announcement is made of the implementation of our Retirement Investment Program.

In the next few weeks you will receive an individual proposal on the Program. I urge you to give it your most careful consideration. In the judgment of Council and your Special Trust Committee, the Retirement Investment Trust is one of the most useful services ever offered by the Association for the benefit of our members.

This offering is the result of five years of study, hard work and, on occasion, facing apparently insurmountable frustrations. The various facets of the program could not have been integrated into a workable program without the untiring efforts and determination of Mr. J. Banks Shepherd, our Administrator. Due credit also must be given to Mr. Charles Gates, Jr., Vice President and Trust Officer of the Charleston National Bank of Charleston, West Virginia. Mr. Gates has worked closely with Mr. Shepherd and members of the committee in helping to solve the many problems that have arisen. The Trust Department of the Charleston National Bank has offered not only impressive advantages to those of us who participate in the trust, but has also absorbed the sizeable financial cost of our studies.

This report will not go into the program in detail. When you receive your proposal, you may study it at your leisure and do not hesitate to call Mr. Shepherd or a member of the Special Trust Committee if there are any questions. If invited by a component society, the Trust Department of the Bank, in order to better explain the program, has offered to make available a member of its staff to attend that component society meeting. However, your committee would like to point out that under most circumstances investment management is too costly and diversification not practical when undertaken on an individual basis.

Through the Association, a Special Trust Agreement has been worked out with the Charleston National Bank—the State's largest bank with an established record in the field of trust administration and investment management. Administration is provided at a substantially lower cost than is available to us on an individual basis. Specifically, you pay no loading charge to enter the plan. Trust administration is provided at approximately one-half of what you would pay on an individual basis.

The Program offers you a balanced investment plan, balancing the potential for growth with basic guarantees. At a time in the future when you choose to reduce the present volume of your practice, returns from your Retirement Investment Plan can provide a significant supplement to your income and a well-earned degree of security.

In summary: The Program is specifically designed for use of our members. Your dollars are put to work under qualified investment management with the objective of growth and a reasonable return. Administration is provided at a minimum cost. At an appropriate time in your future, the Retirement Investment Plan offers you a well-earned degree of security and I recommend in your own interest that you give this Program your most careful consideration.

Group Disability Insurance

Our Group Disability Insurance continues to operate at a very high level of performance. Participation is consistently in excess of 70 per cent of the eligible members. Service is well organized. Members continue to express satisfaction at prompt and efficient handling of claims and other policy services.

The following three revisions have been made in our Group Disability Insurance Program:

(1) The first is an adjustment in Catastrophe Hospital rates. This is part of a countrywide revision of both group and individual rates for this type of insurance. It is made necessary by the increase in hospital costs. The group rate for Catastrophe Hospitalization is comparatively low. Even with the revision the premium is relatively modest.

(2) The limit of monthly indemnity under our income protection is being raised from $600 to $1,000. The new limit brings the monthly indemnity available more in line with our requirements.

(3) In order to put our Disability Insurance Programs on an actuarily sound basis and to standardize forms under which this insurance is written, all plans are being renewed on a monthly indemnity basis and premiums on a step rate basis. Nearly all plans are already on this basis—only those who have weekly indemnity plans are affected.

Million Dollar Liability Policy

The Million Dollar Catastrophe Liability Policy was negotiated on a group basis last year. The requirements of the underwriter have been met and the policy is now in force. For the benefit of you who may have overlooked this form of coverage, this policy provides a Million Dollars excess protection over your regular liability policies. It covers automobile, malpractice and liability on your home, office and personal activities. The increasing number of really large verdicts resulting from malpractice and automobile claims makes this policy of special interest to members of the medical profession.

This policy is not intended to replace or interfere with any of your present insurance—business or personal. It is excess coverage and is in addition to coverage now provided by your present insurance. If you haven't already availed yourself, I suggest you talk to the representative at his booth in the Exhibit Center or drop him a note. He will be glad to answer your questions.

*Other annual reports were published in the August, 1964 issue of The Journal.

Future Planning

Our Group Life Plan is being revised. The new program will offer up to $40,000 Life Insurance in increments of $10,000. The new plan includes double indemnity, waiver of premium and full conversion privileges. It affords you an unusual opportunity to provide your family with an extra $40,000 of protection at extremely favorable rates. This plan will be available as soon as details are complete. It is now estimated at about the first of the year.

There are still many other possibilities in the field of insurance protection for our members to be investigated, but the Committee assures you that it shall be untiring in its efforts to develop an insurance program for the West Virginia State Medical Association which will be comparable to any in the nation and far superior to the great majority.

Respectfully submitted,

C. A. Hoffman, M. D.
Chairman.

Special Committee Named to Study The Scholarship Program

Following several meetings of the Committee named to Study the Scholarship Program of the West Virginia State Medical Association, the members agreed unanimously that the principles of the Charles Lively Memorial Scholarship Fund should be preserved, namely the provision of encouraging young physicians to practice in rural areas.

We believe that provisions for emergencies which confront students during their schooling, where these students are demonstrating firm intent and good performance, and where these emergencies cannot be met by other means, should be made and the State Medical Association should provide, if possible, emergency loan funds for this relief to be administered through and with the advice of the Dean and the Committee on Student Welfare of the West Virginia University School of Medicine.

It has been reported to the Committee that these emergencies often arise on such short notice that the students cannot be helped by the AMA-ERF, or other sources of loan funds.

The Committee recommends that the present scholarship program be followed with the following specifications:

Two four-year scholarships be awarded annually as in the past to students enrolled in the School of Medicine with the understanding that the recipient would, by contract, agree to repay the money beginning one year after starting into practice or not more than seven years after graduation, with interest set at 6 per cent per annum. The student is to be given the opportunity to repay the principal and interest by practicing in one of the designated rural communities in the State at the rate of $1,000 plus accrued interest thereon per year of such practice.

It is further recommended that the emergency loan fund be continued and enhanced as much as is deemed advisable in the opinion of the Scholarship Committee.

Respectfully submitted,

E. Lyle Gage, M. D.
Chairman.

Committee on Medical Education, Hospitals and Scholarships

Your Committee on Medical Education, Hospitals and Scholarships has been active during the past year and it is a pleasure to report that committee meetings have been attended faithfully by the members.

In addition to the pleasant task of selecting recipients for the two four-year medical scholarships awarded by the West Virginia State Medical Association, the committee also took action on several important matters.

Your Committee is of the opinion that there should be established two separate standing committees in lieu of the present committee. The responsibility of one committee would be to deal with the scholarship program of the Association, while the other committee would be concerned with medical education and hospitals in the State. Therefore, amendments to the By-Laws will be introduced tonight which would establish committees on (1) Medical Scholarships, and (2) Medical Education and Hospitals.

We believe that the responsibilities now assigned to the one Committee are too great and therefore it is our hope that you will give approval to the proposed amendments.

It was brought to the attention of the Committee last year that there are many instances when students enrolled in the West Virginia University School of Medicine find themselves in situations where they need immediate financial assistance. The Committee was unanimous in its belief that some of the surplus funds in the Association's Scholarship Fund should be used to help alleviate this situation.

The Committee unanimously directed that the sum of $4,000 be placed with the West Virginia University Foundation, establishing a Division of the Charles Lively Memorial Scholarship and Loan Fund of the West Virginia State Medical Association to make loans to medical students by utilizing established School of Medicine, University and West Virginia University Foundation procedures.

The Committee stipulated that applicants must be members of the second, third and fourth year classes at the West Virginia University School of Medicine, and that such applicants must demonstrate need to the satisfaction of the School of Medicine Faculty Committee on Student Welfare.

The maximum loan available from this source to any student during one academic year is $400 and each loan shall bear interest at the rate of 4 per cent per annum beginning one year after receipt of the M. D. degree or one year after leaving the School of Medicine for any cause. Full repayment will be expected by the end of the third year following receipt of the M. D.

degree or after leaving the School of Medicine for any cause.

The Committee directed that each student receiving a loan from this fund be informed by the Welfare Committee that the funds were made available by the West Virginia State Medical Association. Also, the Chairman of the Student Welfare Committee was directed to notify the headquarters offices of the name of each recipient of a loan from this revolving fund, and the amount of the loan.

It is evident to the Committee that there was a definite need for money to establish an emergency loan fund for our medical students. The entire amount of $4,000 which was made available during the past school year was exhausted during the first six months of this year. We were greatly pleased that it was possible for the State Medical Association to aid eleven worthy and needy students.

Our experience during the past year has demonstrated to the Committee that the Association should make every effort possible to continue to place funds with the University Foundation annually so that there may be a source of funds for emergency loans. We believe that the funds can best be administered by the University Foundation and its established administrative procedures, rather than making it necessary for the State Medical Association to enter the banking business.

We believe by utilizing surplus in the Scholarship Fund and the funds derived from an appeal to our membership for contributions to the Charles Lively Memorial Scholarship Fund, we will be able to place money in an emergency loan fund in addition to awarding the two four-year scholarships.

As you know, $6 of the annual dues of each member is earmarked to the Medical Scholarship Fund. The Committee has given much thought to various methods which could be employed in seeking additional money for the Scholarship Fund. It was the consensus that solicitation should be limited to physicians and perhaps some of the allied professions. We believe that officials of West Virginia University and other educational institutions might object to the State Medical Association competing with their efforts to obtain funds from industry and the general public.

As I have mentioned on previous occasions, the original idea of our Association through the work of the Medical Scholarships Committee, was to help capable and needy medical students obtain a medical education and, in so doing, provide our rural areas with better medical care. We believe that by continuing to award two scholarships annually, together with providing money for an emergency loan fund, we will be able to achieve these goals.

Therefore, on behalf of the Committee on Medical Education, Hospitals and Scholarships, I offer the following resolution which we hope will meet with the approval of the members of the House of Delegates:

As a result of several years experience in the conduct of our Medical Scholarship Program, your Committee, after thorough and continuous study of all matters relating thereto, by majority vote wishes to offer the following resolution:

BE IT RESOLVED, By the House of Delegates of the West Virginia State Medical Association, that the present Medical Scholarship Program be continued as in the past under existing regulations, with the exception that recipients of such scholarship grants who do not comply with the terms of a written agreement to practice medicine for a stated period of time in selected rural areas shall be required to repay the full amount of such scholship grant, beginning one year after starting into practice or not more than seven years after graduation, with interest on the unpaid balance at 6 per cent per annum, on a schedule of repayment satisfactory to the Committee on Medical Scholarships.

Respectfully submitted,

J. P. McMullen, M. D.
Chairman.

Necrology Committee

The following is a list of West Virginia physicians whose deaths have been reported to the West Virginia State Medical Association during the past year:

1963

Aug.	29—John G. Rogers	Vienna
Oct.	9—Don Shelly Benson	Moundsville
Oct.	11—John Sayre Hayman	Huntington
Oct.	14—McRae C. Banks	Ralcigh
Oct.	18—Fred A. Brown	Barboursville
Oct.	22—Henry Lawrence Robertson	Charleston
Nov.	5—Albert Pierce Traynham	Sweetsprings
Nov.	6—Elliot Moses Namay	Charleston
Dec.	5—Glenn Walton Brewster	Cincinnati, Ohio
Dec.	10—August Milton French	Logan
Dec.	15—Thomas Franklin Garrett	Beckley
Dec.	22—William Arthur Adams	Parkersburg
Dec.	22—Robert W. Bess	Piedmont
Dec.	22—Hareld Sinclair Tait	Wheeling

1964

Jan.	7—Albert Updike Tieche	Beckley
Jan.	12—Marcus Emmett Farrell	Clarksburg
Jan.	20—R. W. Quaintance	Slate Mills, Virginia
Feb.	3—Alfred Spates Brady, Jr.	Charleston
Feb.	4—Doff D. Daniel, Sr.	Beckley
Feb.	10—Wilmer G. Oliphant	Knoxville, Tennessee
Feb.	17—Horace Allen Whisler	Clarksburg
Mar.	4—Howard R. Crews	Huntington
Mar.	6—Rufus Emory Woodall	Charleston
Mar.	6—Dean Leonard Hosmer	Bluefield
Mar.	14—Charles Randolph Hughes	Bluefield
Mar.	19—Ira Connolly	Parkersburg
Apr.	3—Matthew Francis C. Zubak	Wheeling
Apr.	23—Robert Thornhill Coffman	Cincinnati, Ohio
May	13—William Byrd Hunter	Coral Gables, Fla.
May	25—Joseph Charles Peck	Moundsville
June	13—Charles G. Polan	Huntington
June	19—Charles N. Watts	Charleston
June	24—Otis E. Reynolds	Huntington
July	16—Creed C. Greer	Clarksburg
July	23—Gordon L. Todd, Jr.	Princeton

Respectfully submitted,

Andrew J. Weaver, M. D.
Chairman

August 19, 1964.

Resolutions

Resolutions offered at the first session of the House of Delegates on Wednesday evening, August 19, 1964, were referred to the Committee on Resolutions for study and report back, with recommendations, at the final session on Saturday afternoon, August 22.

Dr. J. C. Huffman of Buckhannon, the Chairman, presided at a meeting of the Committee which was held on Thursday afternoon, August 20.

Upon request by the sponsors, two resolutions which had been prepared were withdrawn from consideration. Another resolution to encourage physicians to settle in rural areas was referred to the Special Committee named to meet with the Medical Licensing Board.

As recommended by the Committee, the House of Delegates adopted the following resolutions:

Resolution No. 1. Establishment of a Chaplaincy Training Program at the West Virginia University Hospital—By the Kanawha Medical Society.

WHEREAS, Medical Education in West Virginia is centered at West Virginia University and the Medical Center Hospital; and,

WHEREAS, There is a recognized need to help the clergy of our State become better acquainted with clinical aspects of hospital ministry in order that they can better serve the religious needs of patients;

THEREFORE, BE IT RESOLVED, by the House of Delegates of the West Virginia State Medical Association, that it favors the creation of a Hospital Chaplaincy Program and a Hospital Chaplaincy Training Program at the University Hospital, the details of this program to be worked out by a joint committee of physicians and clergy.

* * * *

Resolution No. 3. Medical Scholarship Program—By the Committee on Medical Education, Hospitals and Scholarships.

As a result of several years experience in the conduct of our Medical Scholarship Program, your Committee, after thorough and continuous study of all matters relating thereto, by majority vote wishes to offer the following resolution:

BE IT RESOLVED, By the House of Delegates of the West Virginia State Medical Association, that the present Medical Scholarship Program be continued as in the past under existing regulations, with the exception that recipients of such scholarship grants who do not comply with the terms of a written agreement to practice medicine for a stated period of time in selected rural areas shall be required to repay the full amount of such scholarship grant, beginning one year after starting into practice or not more than seven years after graduation, with interest on the unpaid balance at 6 per cent per annum, on a schedule of repayment satisfactory to the Committee on Medical Scholarships.

* * * *

Resolution No. 4. Legislation to permit Professional Persons to Practice as Corporations—By the Parkersburg Academy of Medicine.

WHEREAS, The practice of medicine as a group or partnership is aided in many ways by the ability of such groups or partnerships to incorporate; and,

WHEREAS, Such incorporation does not alter the physician-patient relationship, nor permit lay control of medical practice; and,

WHEREAS, The legislatures of 33 states of the United States have enacted legislation permitting professional corporations to be formed;

THEREFORE, BE IT RESOLVED, That the West Virginia State Medical Association favors the principle of incorporation as outlined; and hereby recommends that the Legislature of the State of West Virginia amend Chapter 31 of the Code, the Corporation Act, as soon as possible, to permit the formation of Medical Corporations within this State.

* * * *

Resolution No. 6. Reapportionment for the House of Delegates and the Council—By the Kanawha Medical Society.

WHEREAS, At present, the By-Laws provide for one delegate to each 25 members, or fraction thereof, of each component society; and,

WHEREAS, The result of the above is, in some instances one delegate to every three and a half members, and in other instances, one delegate to 22 members, resulting in grossly unfair representation;

WHEREAS, The Constitution and By-Laws fail to provide in any manner for the apportionment of the Council membership and memory serveth not to recall the basis of their apportionment;

THEREFORE, BE IT RESOLVED, That the Committee on Constitution and By-Laws be instructed to review the above factors and be further instructed to bring before this group recommendations for changes in the By-Laws to provide for (1) Fair representation in this House of Delegates, and (2) Fair apportionment of the Council of this Association.

* * * *

Resolution No. 8. Sufficient Funds for the Operation of the Commission on Postmortem Examinations—By the Kanawha Medical Society.

WHEREAS, A bill providing for the establishment of a Commission on Postmortem Examinations was passed by the West Virginia Legislature in 1963; and,

WHEREAS, The need for such a Commission has become so great;

THEREFORE, BE IT RESOLVED, By the House of Delegates of the West Virginia State Medical Association, that it strongly urges the State Legislature to appropriate sufficient funds during the 1965 session for the operation of the Commission on Postmortem Examinations.

Report of Resolutions Committee

The Chairman of the Committee, Dr. J. C. Huffman, submitted his report to the House of Delegates at the final session on Saturday afternoon, August 22, 1964. The report follows:

Your Committee on Resolutions has carefully considered the resolutions offered before the first session of the House of Delegates on Wednesday evening, August 19, 1964.

Several members of the Association appeared at a meeting of the Committee held on Thursday afternoon, August 20, 1964, and discussed in detail the resolutions pending before the Committee. The cooperation of these physicians has been most helpful to the Committee in reaching decisions, and we express appreciation to those who took time to attend the open hearing.

Mr. President, your Committee assures the members of the House of Delegates that the one and only consideration that has guided the Committee in its deliberations has been the criteria as to whether each of the resolutions were or would be to the best interests of the entire medical profession in West Virginia.

Mr. President, we wish to thank the members of the West Virginia State Medical Association who appeared before the Committee at the open hearing on August 20, 1964.

Your Chairman personally expresses his gratitude to the members of the Committee for the patience, enthusiasm, wisdom and valuable time devoted to the study of the resolutions.

In addition to your Chairman, the members of the Committee participating were Dr. Maynard P. Pride of Morgantown; I. Ewen Taylor of Huntington; Pat A. Tuckwiller of Charleston; and William H. Lively, secretary ex officio, and Jerry Gould, executive assistant.

Courtesy Resolutions Adopted

Dr. James S. Klumpp of Huntington requested and obtained the unanimous consent of the House for the introduction of four courtesy resolutions. The resolutions which follow were adopted unanimously:

Resolution No. 9. Coverage by News Media of All Sessions at The Greenbrier.

Many of the events and discussions which occur during our Annual Meeting are of local, State and even national interest, and the adequate communication of such information is important both to the public we serve and to our profession,

THEREFORE, BE IT RESOLVED BY THE HOUSE OF DELEGATES OF THE WEST VIRGINIA STATE MEDICAL ASSOCIATION, That our Executive Secretary be directed to extend our formal thanks to the areas of communication involved, radio, press and television, for their wholehearted cooperation in this field.

* * * *

Resolution No. 10. Distribution of Morning Newspaper by the Hospital and Physicians Supply Company of Charleston.

Over the years the members of our Association have been afforded the pleasure of having a copy of The Charleston Gazette left at their respective doors, with the opportunity of keeping posted on current events while away from home,

THEREFORE, BE IT RESOLVED BY THE HOUSE OF DELEGATES, That our Executive Secretary be directed to extend our thanks to the Hospital and Physicians Supply Company of Charleston, West Virginia, for this continued courtesy.

* * * *

Resolution No. 11. Appreciation for Cooperation of Management and Personnel at The Greenbrier.

The members of the Association, their families and our guests look forward with eager anticipation to their annual stay at The Greenbrier,

THEREFORE, BE IT RESOLVED BY THE HOUSE OF DELEGATES OF THE WEST VIRGINIA STATE MEDICAL ASSOCIATION, That our Executive Secretary shall be directed to extend to the operating and service personnel of The Greenbrier our sincere thanks for their efforts in making our short stay so very pleasant.

UNITED

The West Virginia Medical Journal

November, 1964 Vol. 60, No. 11

Special Report

Kanawha Medical Society's Welfare Evaluation Committee

(A Comment on 'Idleness' As a Disease)

Preface

The Department of Welfare has not upgraded the physical examinations commensurate with progress in other medical areas. It is the consensus of this Committee that the welfare program has operated for three decades with a philosophy which has caused harm to its "clients." There is need for greater emphasis on rehabilitative efforts for welfare clients. There is much to be done to help those already on welfare; however, the greatest effort should be directed toward rehabilitation of new "clients."

Committee Members

The following members of the Kanawha Medical Society were appointed to conduct this study:

- **William D. Crigger, M. D.**
  Chairman
  Edwin M. Shepherd, M. D.
  Coordinator
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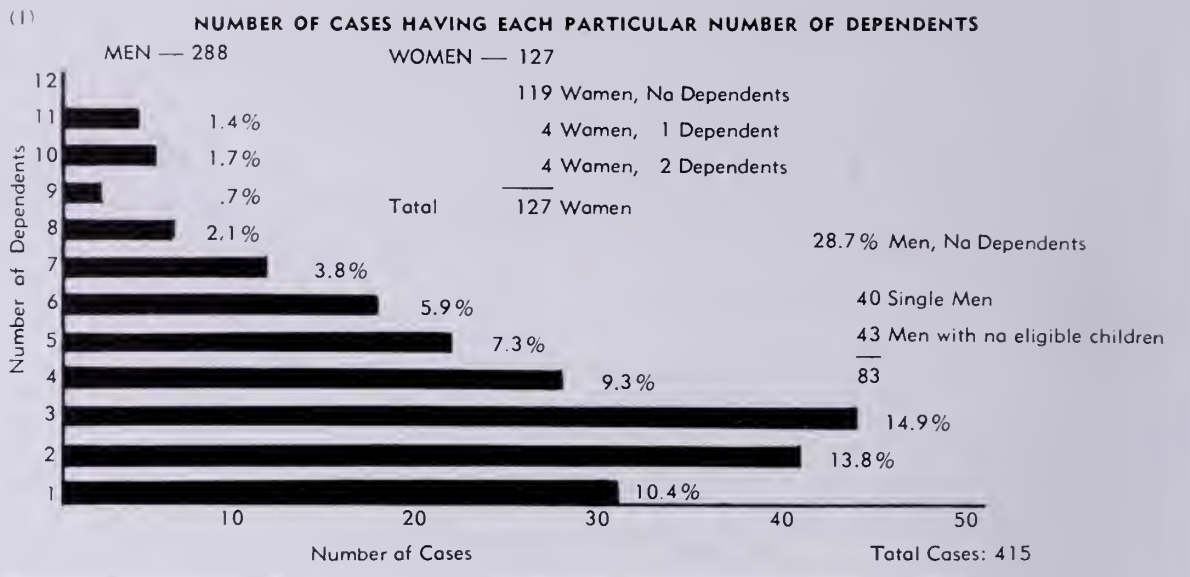
This is the second report of the Kanawha Welfare Medical Evaluation Committee on a study of the "clients" of the Kanawha County Department of Welfare. A previous study was submitted to the Department of Welfare in November, 1962 and subsequently published in *The West Virginia Medical Journal* in December of 1962.

This Committee was authorized by the Kanawha Medical Society and the Commissioner of the Department of Welfare to evaluate the validity of medical findings in relationship to eligibility and to establish a procedure for examinations that could serve as a guide for such examinations on a state-wide basis. This entire report covers a period of two years and is a study in depth of the mental and physical condition of the cases under study.

The initial report presented the findings of an examination of 329 clients. This report presents the results of the findings of examinations of 415 clients. All of these clients were on the welfare rolls and receiving assistance and all had been examined by physicians. The impairments found by these physicians were judged by the Department of Welfare to cause them to be disabled under the existing rules and regulations.

The examination of the second group of clients was conducted in two phases. The first phase was conducted at Charleston General Hospital by a panel of physicians. Following the examinations, the cases were discussed by a conference group consisting of members of the Department of Welfare, Division of Vocational Rehabilitation, Goodwill Industries and the examining physicians. Recommendations were subsequently made on each case to the Department of Welfare.

***The graphs in this article do not necessarily agree with the total numbers expressed in our report since some patients have multiple disabilities.**

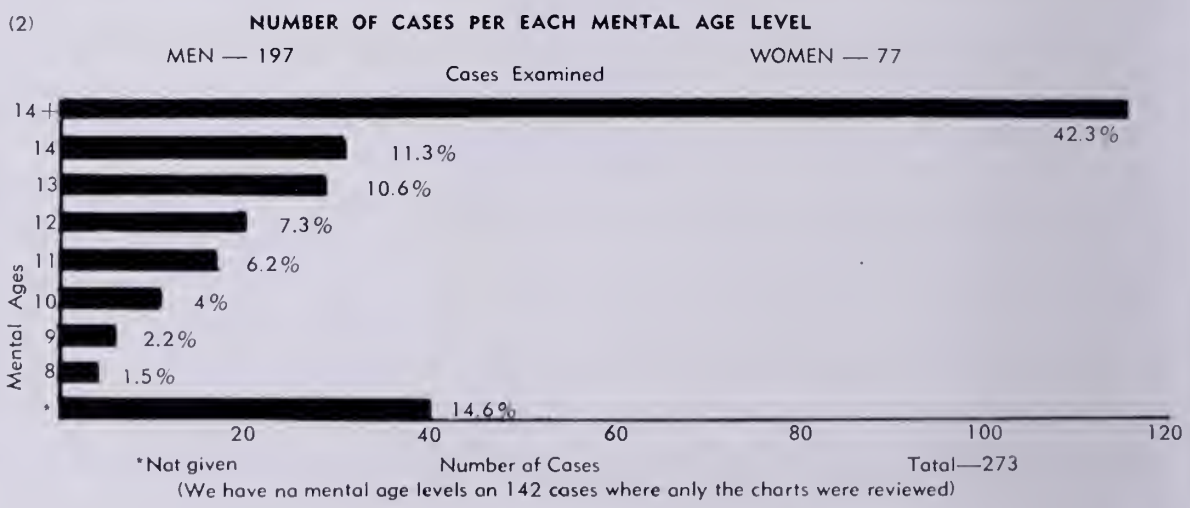


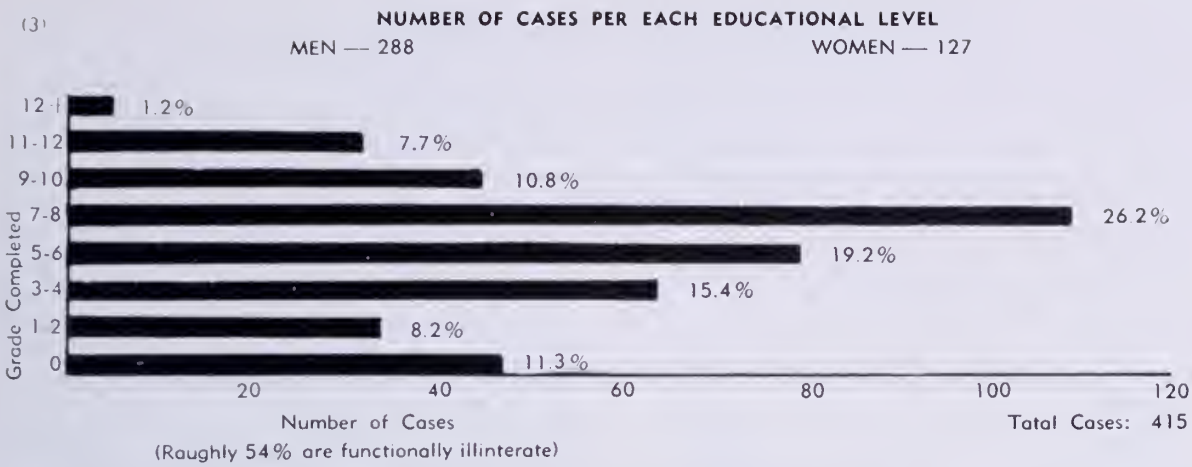
The second phase was conducted at Charleston Memorial Hospital and was a clinic-type examination. There were more clients involved in the second phase and more specialties represented in the examining body. Included in the total examining staff were students from the West Virginia University School of Medicine, faculty members of the WVU School of Medicine, faculty members of the School of Social Work and School of Psychology at the University, members of the staff of the Department of Welfare, Division of Vocational Rehabilitation and physicians of the Kanawha Medical Society.

Of the 415 patients surveyed, it was found that 55 men and 65 women had sufficient impairments, in the opinion of those on the Panel, to justify a label of permanent and total disability. Twenty-eight (28) others were classified as temporarily totally disabled because they were convalescing from recent illness or injury.

There were gray areas which accounted for another 62 men and women. One group did not have sufficient education or training to do anything but unskilled labor and hence because of their impairments were not able to work. Thirty-five (35) of these were recommended to some type of sheltered workshop† (a program not yet in existence), a program that should enable a man or woman to be partially productive and to contribute something toward his support as well as to his family and community. Twenty-seven (27) were referred directly to two projects of rehabilitation, one of which was beginning under the joint auspices of the Department of Welfare and the Division of Vocational Rehab-

†Sheltered Workshops have not been made available.





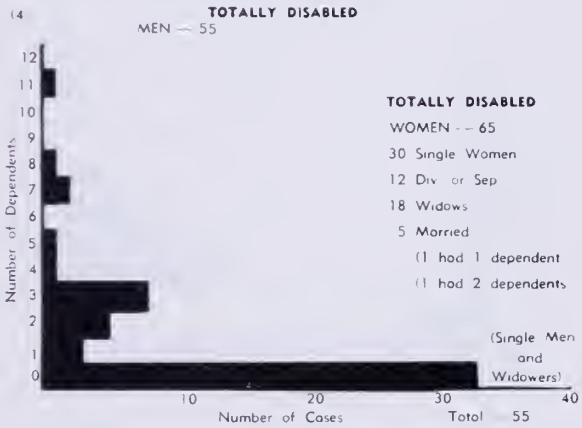
ilitation (Project No. 1335). This project resulted from the recommendations of our previous study. The second project is an entirely new approach for the mentally retarded, by the Division of Vocational Rehabilitation. We are unable to report any follow-up on these patients due to the newness of the projects.

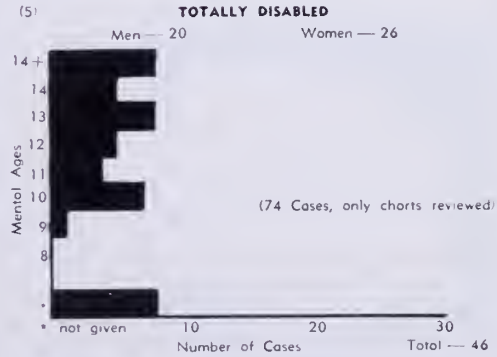
During the process of our examinations, 88 cases were closed by the Department of Welfare after the review of the welfare case record and before some of the patients or clients could be brought in for examination. In some of these cases we were not apprised of the reason for closure, but on investigation found that some had moved and approximately 40 had returned to employment.

Forty-three (43) men and women were examined and found to be able-bodied and potentially employable. An additional 28 were recommended to the ADCU work program, 23 to Project No. 1335 (the rehabilitation program of the Department of Welfare and Division of Vocational Rehabilitation), 4 to Project No. 957 (the rehabilitation program for the mentally retarded at Vocational Rehabilitation), and 38 were referred directly to the Division of Vocational Rehabilitation for further training.

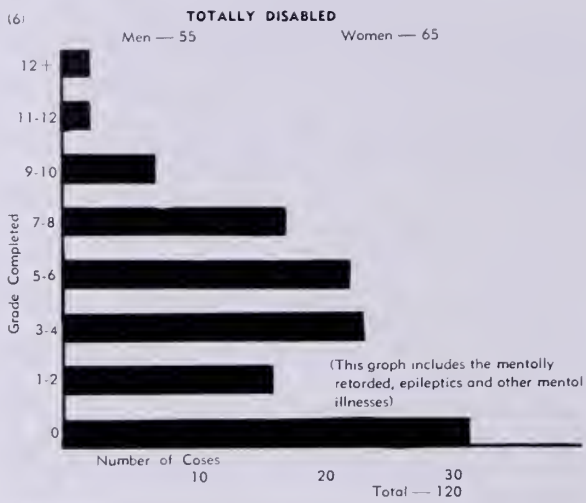
We again noted that the most severely impaired had the lowest average mental age levels and the lowest grade levels achieved in school, and the largest number of children.

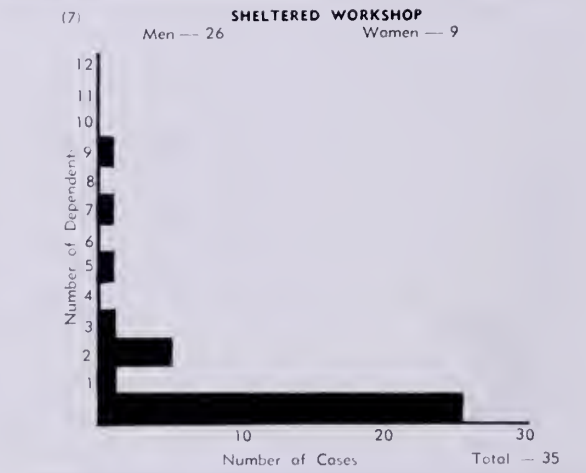
We have repeatedly seen throughout the study examples of persons examined by their family physicians with treatment recommended, and the recommendations then delayed months, even years before being initiated either by the Department of Welfare or the client. Under the law the welfare worker cannot force a client to accept or follow therapy. There remains the unhappy alternative of no therapy and maintenance of welfare status or therapy and the necessity of returning to work (which now exists in the client's mind whether the Welfare Department realizes it or not). It is becoming increasingly obvious that some change in the approach by the Department of Welfare is going to be necessary to make therapy acceptable to some welfare clients. Acceptance of therapy might be made a condition by which eligibility is maintained.

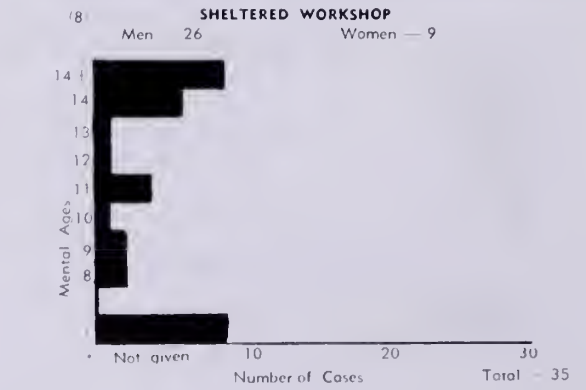




A case in note—a forty-eight-year-old white male was seen by his physician and referred for treatment. When first seen, the man had chronic bronchitis diagnosed by x-ray, which was probably treatable, and the patient could have been returned to employment. But, when finally seen by a specialist three years later, the illness had progressed to emphysema and bronchiectasis of such magnitude that rehabilitation was out of the question.







Several cases were brought to our attention of clients being placed on the welfare rolls for relatively minor illnesses who had not been reexamined for 10 to 14 years. Frequently in these cases, we were unable to find any major illness except the "Disease of Idleness" which had caused a severe loss of muscle tone and these people were now poor or hopeless prospects for any rehabilitation effort. We, of course, recognize the dilemma of six or more starving children and a father who is unemployed. According to our laws, the man must be totally disabled before drawing any money immediately to feed his family. Placing these people on the disabled list of welfare was often a humane but misguided effort. At the time this was done, neither the physician nor the welfare worker realized the severe consequences of the rating of disability. There has been a tendency over the years for the physicians to blame the welfare worker and the Department of Welfare, and the Department of Welfare to blame the physicians, when in reality the basic laws with their regulations were at fault.

There were eight cases of diabetes, none of which were under control at the time of our examination. These people had deteriorated because of arteriosclerosis and other complications of diabetes, complications which are hastened or even caused by very poor control. It seems almost inhuman to hand out money to these people without proper instruction and follow-up care, and without financial assistance being contingent upon their following prescribed dietary and medical check-up. Had this been done with these diabetics, most could have been employable at the time of our examination. Again, let it be emphasized that the legal setup of welfare is not conducive to the voluntary acceptance of therapy and the workers cannot under the law demand any compliance.

Psychiatric illness, including chronic brain syndrome, accounted for 89 men and 59 women who had mental impairments sufficient to justify a rating of disability. This is by far the largest number rated disabled and they were of the lowest mental age and school performance.

In the present study of 273 clients examined, 151 were found to have insufficient impairment to justify a rating of disability. One hundred forty-two (142) charts were reviewed only, making a grand total of 415 clients. Some of those examined were found to have hernias, plantar warts and other simple lesions that could have been repaired at the time of their initial examination. If the social worker had been given authority to encourage medical treatment, idle-

ness could have been eliminated. Idleness has led to loss of work motivation, muscle tone and a change in mental attitude, which can take months or even years for rehabilitation. It was apparent the social workers were held responsible for entirely too many clients.

Throughout our examinations we were impressed by:

(1) The minor afflictions such as plantar warts, diabetes and mild hypertension, etc., which were certified to be permanently and totally disabling with the patient living on assistance for years.

(2) The association of 32 cases of Workmen's Compensation and 8 auto accidents with impending litigation—the majority of these were long-term (over one year) recipients of welfare.

(3) The contribution of long-term idleness to the general debility of the patient—we can cite 17 cases in which idleness was the major factor in the deterioration of recipients to such a degree that rehabilitation was not medically, socially or economically feasible.

We would like to recommend to all who read this article and especially to the Department of Welfare and the physicians of West Virginia that:

(1) Physicians, members of the Department of Welfare and others interested in the welfare problems begin immediately when a patient is first seen to bring to bear on his case all the necessary social, economic and medical modalities for the earliest return to self-sufficiency. We should engender a healthy attitude toward rehabilitation in the entire community, sending all patients back to work as soon as reasonably possible after an injury or illness.

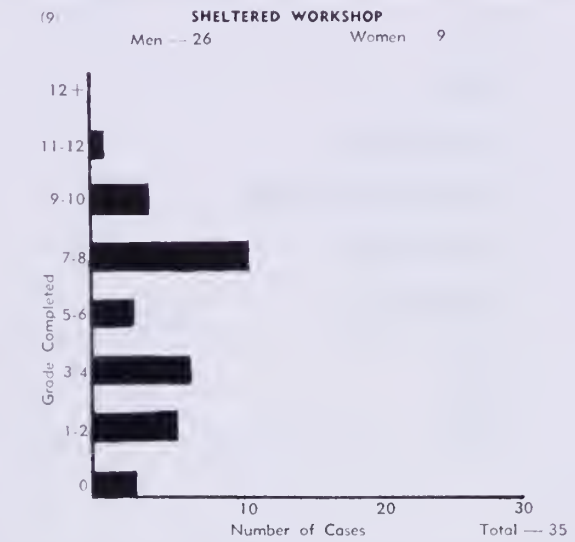
(2) Modification of the law of West Virginia (Chapter 9, Article 5, Section 29) to encourage all clients of welfare to return to gainful employment without penalty, subsidizing them until they become self-sufficient. Under the present Federal law, such is possible.

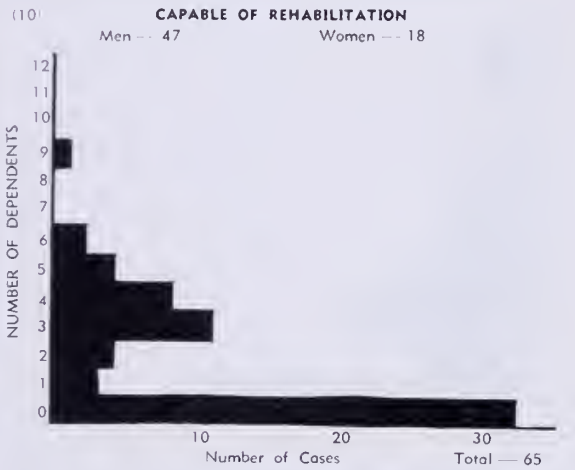
(3) Closer liaison between the Department of Welfare and all rehabilitation agencies that serve to aid the handicapped.

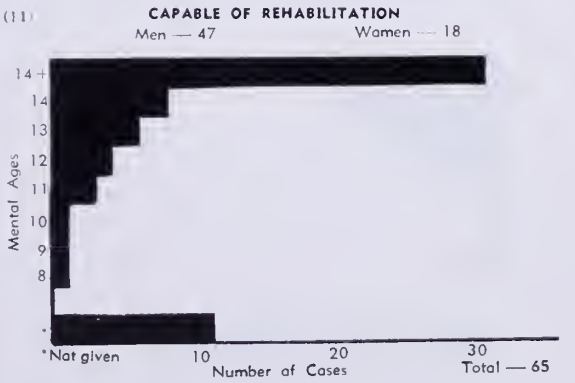
(4) Immediate authorization by the Department of Welfare for repair of hernias and other correctable conditions be they surgical, medical or orthopedic, avoiding years on welfare before anything is done or years before Vocational Rehabilitation has sufficient funds to give assistance. Presently in the Department of Welfare, a client may not have an elective procedure such as a herniorrhaphy or a fitting of an arm or leg until it becomes an emergency or a life-saving procedure.

(5) Sheltered employment should be established and appropriate personnel assigned. The aim of this employment should be retraining and re-evaluation of the individual for the specific purpose of improving his abilities so that he may become totally or at least partially self-sufficient.

(6) We would recommend that the format of welfare examinations be changed and that available social history and medical data be given to



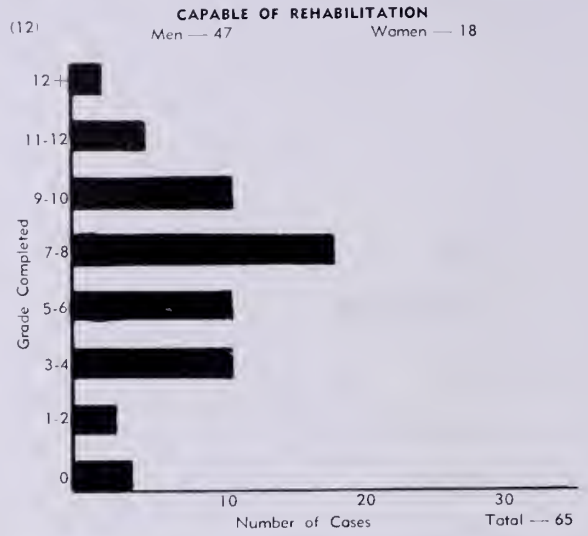


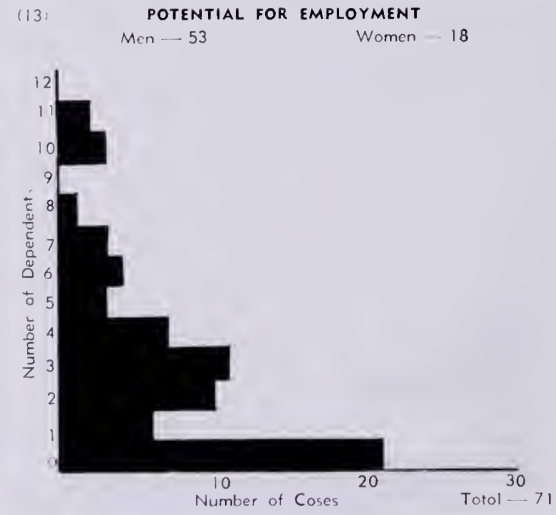


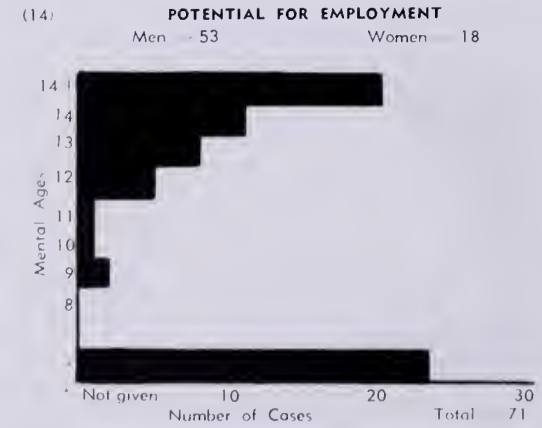
the examining physician, allowing him to make a better evaluation of the patient.

Other recommendations follow:

First, the method of inquiry into each case be broadened.





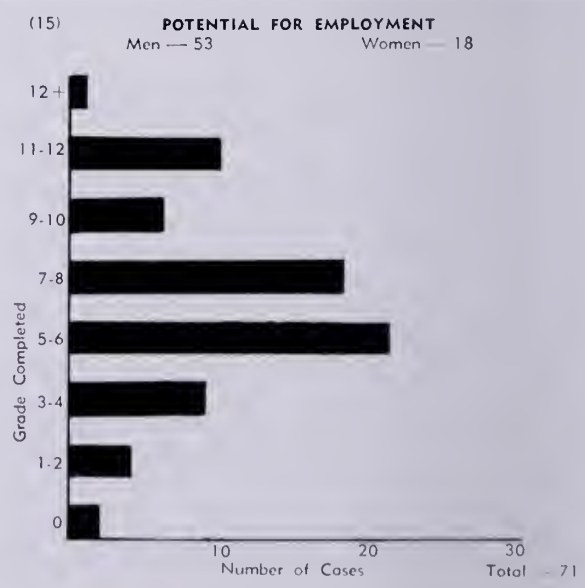


Second, that no ratings of impairment be transmitted as final to the executive branch of government for definitive action until reviewed by a Panel of seven as listed below. These seven people preferably should be physicians from the fields of psychiatry, internal medicine, general surgery, orthopedic surgery and general practice. And one representative each from the Division of Vocational Rehabilitation and the Department of Welfare. It is desirable that the Department of Welfare representative be a social worker who knows the people under discussion.

Third, the physician initially examining a patient for welfare determination of disability be given a realistic fee for his services and be considered as making the initial report for the Review Panel.

In view of the devastating effect of a mistaken label of disability on the mental and physical state of a person and the resultant high cost of maintaining anyone so labeled, the detailed and careful examination here advocated for each candidate appears fully justified to the Kanawha Medical Society's evaluating group. We believe that a method of accepting relief clients on a quick, unclassified basis should be developed by the Department of Welfare to avoid possible hunger and privation on the part of the applicant client while awaiting proper evaluation. This would avoid the present conflicts which are (1) a tendency of both worker and physician to declare disability in an effort to obtain immediate relief benefits and (2) reluctance of the client to accept short-term work because of the length of time required to reinstate himself on welfare.

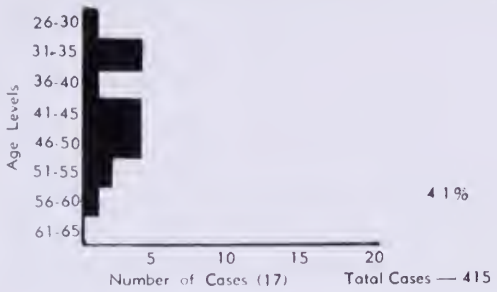
Our suggestion for an examination form is available from the Kanawha Medical Society.



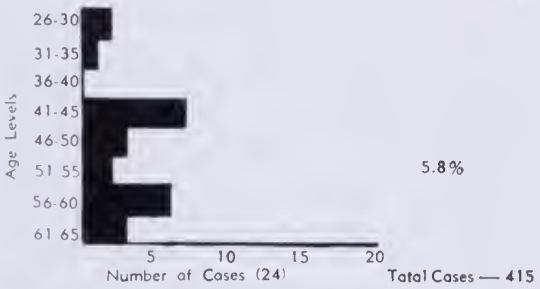
Acknowledgements

1. Department of Welfare for its assistance in supplying office equipment, supplies and financial aid for secretaries.
2. West Virginia University School of Medicine, School of Psychology and the Department of Social Work for their assistance in the Clinics.
3. West Virginia Academy of General Practice whose members from all parts of the State attended a Seminar and assisted in the clinic evaluation on March 8, 1964.
4. Kanawha Medical Society.
5. Division of Vocational Rehabilitation for its assistance with the psychological evaluation and intelligence tests.
6. Goodwill Industries for its participation in placing some of the individuals in the Goodwill Industries for rehabilitation procedures.
7. Charleston Memorial Hospital for the use of its facilities for the Sunday clinics.
8. Charleston General Hospital for the use of its facilities for the clinics.
9. Shepherd Hospital in providing rent-free accommodations for housing this Committee, underwriting heat, light and telephone services.
10. Monies collected for the accomplishment of our 1964 studies were funded and accounted under the auspicies of the Committee on Welfare Investigation of the Kanawha Welfare Council, Inc.
11. The following for their financial assistance—
    Kanawha Medical Society
    McDonough-Caperton-Shepherd-Goldsmith
    Mr. J. W. Herscher
    Lamb Foundation

(16) "DISEASE OF IDLENESS" AS ONLY CAUSE OF DISABILITY



(17) "DISEASE OF IDLENESS" AS PARTIAL CAUSE OF DISABILITY



Air Pollution, Respiratory Disease and the NTA*

Robert J. Anderson, M. D.

This Conference is important to us in the Public Health Service as well as to you because you are discussing here your program priorities and areas of emphasis for the coming year. We are hoping, of course, that many of you will decide to put at least a little emphasis on the subject of my talk today—air pollution.

It has occurred to me that there is a striking parallel between your relation to your national organization and the relation of state and community air pollution control agencies to the Public Health Service. Before I close, I mean to review briefly the new Federal Clean Air Act and discuss the possible role of voluntary associations such as yours in combatting air pollution. But let me say at this point that while the new law will enable us to provide more leadership and more assistance to state and communities, it still will not permit us to dictate to them what control measures they shall take. Similarly, each of you is free, to a great extent, to choose what issues your own local group will emphasize. In my opinion, air pollution is a major national issue today and one that is worthy of serious attention by your great Association.

Air pollution also seems to me to be straight "down the alley," the alley you have patrolled for so many years with spectacular success. In fact, I have been asked specifically to cover in my talk the relation of air pollution to your own area of primary interest, that is, respiratory disease.

Before I do that, however, I want to tell you enough about the sources and extent of air pollution to help you realize how serious and ubiquitous the problem has become in this country.

Sources and Extent of Air Pollution

The safest generality that can be made about the causes of air pollution is that all of us share the responsibility for fouling our air resource. The principal sources are industrial and commercial, automotive, municipal and individual. These all overlap. Industries and stores as well as individuals operate cars and trucks. Some power plants are municipally owned, and municipalities as well as householders burn refuse. And, of course, it is individuals—people—who run our industrial and commercial enterprises. These people suffer with the rest of us from the ill effects of dirty air. To perhaps a greater extent than any other current problem of the public health and welfare, air pollution is everybody's business.

A generation or two ago, about the only air pollutants to arouse public concern were solid particles such as smoke and soot, and these were widely regarded as welcome signs of industrial activity. Excessive smoke still is a problem in many areas, but new kinds of industries have created new kinds of aerial waste, noxious gases and liquid droplets, usually invisible and often odorless. Some of these, triggered by sunlight, undergo chemical changes in the air, and form even more troublesome pollutants, including those responsible for photochemical smog of the Los Angeles type.

As we increase in numbers, congregate ever more thickly in our great supercities, expand our technology, and raise our standard of living, all the sources of air pollution I have mentioned tend to increase. This increase is more than proportional, because each of those growth factors reinforces the others. For example, more people call not only for more home heating plants but also for more factories to produce more cars. And so it goes. The result is that within an almost incredibly short span of time, air pollution has mushroomed from a smoke problem in our industrial cities and a smog problem in Southern California to a major economic, esthetic and public health problem that affects practically every American locality and citizen.

It has been estimated that all U. S. cities of 50,000 or more population and some 6,000 American communities altogether now have air pol-

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lution problems of greater or lesser severity. But the toll exacted by contaminated air is not confined to our cities, for some air pollutants blight vegetation and their ravages are being increasingly felt by farmers and by everyone who grows vegetables, fruit or flowers for profit or pleasure.

Economic and Esthetic Effects of Air Pollution

Agricultural losses alone in this country are estimated at approximately $500 million a year. Current estimates of total economic damage caused by air pollution, nationally, run as high as $65 per person per year or some $11 billion annually. In addition to injury to vegetation and livestock, these estimates include corrosion and soiling of structures and materials, interference with air and surface travel due to lowered visibility, and depreciation of property values.

Air pollution also adversely affects our weather by decreasing the amount of sunshine and particularly of ultraviolet radiation which reaches the earth, and by increasing the frequency and density of fog.

Overlapping to some extent the economic effects of air pollution are its recreational, esthetic and psychological effects. The curtains of smog that can slow up or cancel air flights can also spoil the tourist's view of a natural wonder. The growing of green things that is one man's income is another man's recreation and a source of esthetic satisfaction. When ozone blights a pine forest, it may not only destroy industrial resources but also may ruin the forest for vacationers or sportsmen. It also is a fact that man-made darkness and airborne filth and offensive odors are incongruous in an America that has come to demand the amenities as well as the necessities of life. Americans would resent the gloom and the dirt and the stench even if air pollution were not the costly economic burden it is and, as I plan to demonstrate now, a serious hazard to human health.

Air Pollution and Respiratory Disease

Respiratory disease, of course, is the most important and by far the most costly effect of air pollution. Besides reducing our crop yields, damaging our property, affronting our senses and lessening our enjoyment of life, contaminated air can aggravate our illnesses, deplete our strength and shorten our life span.

All of you have heard about the acute episodes in which exceptionally high temporary concentrations of pollutants brought sudden death. The best known were in Belgium's Meuse Valley, in 1930; Donora, Pennsylvania, in 1948; and London, in 1952. A similar episode in New York City, in 1953, was not recognized until a study of vital statistics nine years later revealed that there had been some 200 deaths in excess of normal there during a brief period of weather stagnation, with unusually high levels of sulfur dioxide and smoke. The most recent such episode to make the front pages was the London smog of December, 1962. Largely because of the intervening passage in Britain of a Clean Air Act, deaths officially attributed to this cause numbered only about 750, as against 4,000 in the 1952 London smog. In all these acute episodes, it was the aged and infirm, and especially the respiratory cripples, who were likeliest to be struck down.

Sensational and tragic as such disasters are, we are even more concerned with the slow, insidious effects of long-continued exposure to much lower concentrations of air pollutants, concentrations such as those which prevail constantly or recur frequently in most of our cities. These prolonged exposures to airborne toxic substances may carry many health effects but our primary interest centers, naturally, on the respiratory system, through which these poisons can enter the body most easily. The report of the Health Panel at the 1962 National Conference on Air Pollution was positive and unequivocal on this point. "The evidence," it concluded, "that air pollution contributes to the pathogenesis of chronic respiratory disease is overwhelming."

This evidence applies to at least six different respiratory ailments. They are (1) nonspecific infectious upper respiratory disease, including the common cold, (2) chronic bronchitis, (3) chronic constrictive ventilatory disease, (4) pulmonary emphysema, (5) bronchial asthma and (6) lung cancer.

(1) The Common Cold.—The common cold and other infections of the upper respiratory tract occur more frequently in areas with high pollution levels. This was indicated in a study in a small Maryland city as long ago as 1950, and since has been confirmed by studies in Great Britain, Japan and the Soviet Union. Further confirmation comes from a large scale American study which still is in progress. This is a check of absenteeism due to illness among groups of employees of comparable socio-economic status, in industrial plants widely scattered throughout the country. It indicates that air pollution, as measured by levels of solid sulfur compounds in the air of communities where the workers live, was associated with increased frequency of acute upper respiratory tract infections.

The laboratory furnishes still more supporting evidence. For example, experiments with animals have shown that certain irritants common in polluted air can slow down and even stop ciliary activity in the air passages. This impairment results in less effective cleansing of the mucous carpet of the air passages and, hence, greater susceptibility to respiratory infection.

(2) Chronic Bronchitis.—In Great Britain, nearly 10 per cent of all deaths and more than 10 per cent of all industrial absences due to illness are caused by chronic bronchitis. We are beginning to find that this condition, or one very similar to it, is of higher prevalence in this country than we thought. One investigation in the United States, using the same criteria as the British, that is, chronic productive cough, most days, for three months of two successive years, found chronic bronchitis in 21 per cent of cases in a series consisting of male patients 40 to 59 years of age.

Cigarette smoking and air pollution are accepted in Great Britain as distinct causes of chronic bronchitis. The evidence for the air pollution factor is very good indeed. Positive association with mortality from this disease has been shown by these air pollution indexes: population density, amount of fuel used, sulfur dioxide air levels, settled dust measures, airborne dust measures and decreased visibility. Persons known to suffer from chronic bronchitis and kept under regular observation, showed increased severity of symptoms on days of higher air pollution.

(3) Chronic Difficulty in Breathing.—The effort required for breathing is increased as a result of inhaling irritant air pollutants. Studies have shown that such pollutants, at levels reached at times in urban environments, can cause constriction of the air passages. This can lead to a persistent nonspecific respiratory condition known as chronic constrictive ventilatory disease. While the healthy person may not notice the extra breathing effort imposed by airway constriction, this added burden may become unbearable to the person whose lungs or heart already are functioning marginally because of cardiorespiratory disease.

(4) Pulmonary Emphysema.—Morbidity and mortality from pulmonary emphysema are increasing rapidly in the United States. In the 10-year period from 1950 through 1959, the number of deaths among males from this cause rose from less than 1.5 per hundred thousand population to nearly 8 per hundred thousand. The extent and cost of this disease are further indicated by social security figures. Of 179,419 persons who received monthly payments for disability in 1960, 12,380 (6.9 per cent) were suffering from emphysema. This percentage was exceeded only by that of persons who had arteriosclerotic heart disease. The total of payments to persons for whom emphysema is the primary medical diagnosis is estimated at $60 million a year.

Patients with pulmonary emphysema become even worse when they are exposed to irritant air pollution. One study demonstrated that when such patients are placed in a room in which the outdoor air of a smoggy Los Angeles day has been purified by electrostatic precipitation and charcoal filtration, they express subjective relief and show objective improvement after 24 hours. The fact that emphysema seems to be increasing especially in urban areas also points to air pollution as a likely factor.

(5) Bronchial Asthma.—This is another condition which often is made distinctly worse by air pollution. There is, of course, a long list of stimuli which are capable of triggering asthmatic attacks and it is not surprising that irritant air pollutants are on this list. But it is rather unexpected to find that sulfur dioxide, an irritant gas known to be present in appreciable concentrations in the air of nearly all communities, actually has been reported to be an allergenic agent with respect to asthma.

As long ago as 1946, a veritable epidemic of asthmatic bronchitis occurred among American troops stationed in the highly industrialized Yokohama area of Japan, and soon spread to dependents who were living in that area. Later the same condition was noted among our military personnel in the Tokyo area.

Although Tokyo-Yokohama asthma still is under detailed study, several important conclusions already have been reached. Removal from the area, especially if early, usually results in recovery. And finally, there is a good correlation between the frequency of asthmatic attacks and air pollution levels.

In the United States, there have been a few experiences with asthma which are at least slightly analogous to the Japanese cases. In New Orleans, epidemic outbreaks of asthmatic attacks have been associated with certain local wind conditions, transporting pollutant particles produced by smouldering city dumps.

There have been other instances, one in Pasadena, another in Nashville, in which epidemiological studies have shown that irritant air pollutants have precipitated attacks of bronchial

asthma in persons known to be subject to such attacks.

(6) Lung Cancer.—The number of deaths from cancer of the lung, especially among males, has been increasing rapidly in recent years. As possibly one of what may be many culprits, too many clues point to air pollution for us to ignore them.

Death from lung cancer has a rate in metropolitan areas in the United States which is twice the national average. In general, the rate is in direct proportion to city size, as generally is the degree of air pollution also.

There are many pollutant substances in the air which are potential cancer producers, and these appear in higher concentration in the air over our large cities. One important group of these chemicals—benzene-soluble organics in suspended particulates—which has produced cancer when injected into susceptible laboratory animals or applied to their skin, increases in concentration with city size very much as does the lung cancer death rate for white males.

A change in air environment apparently can affect the likelihood of development of lung cancer, a conclusion which has been demonstrated in four independent studies.

Laboratory investigations have provided further clues. It has frequently been observed that the rising incidence of lung cancer might well be associated with previous episodes of influenza. Therefore, a selected strain of mice was infected with influenza virus. Those which survived had a slightly higher cancer rate than that of normal controls. But the cancer incidence was increased many-fold by the further exposure of these animals to an artificial smog consisting of ozonized gasoline.

These and other findings strongly suggest that air pollutants, either acting alone or in conjunction with other factors, do contribute to the development of respiratory cancer.

New Confirming Evidence

That there is a distinct link between air pollution and respiratory disease was further confirmed when results of a survey of deaths in and around Nashville, Tennessee, for a 12-year period ending in 1960, were reported last November 12th. This apparently is the first incontrovertible evidence that normal city levels of air pollution affect death rates from diseases of the respiratory system. Altogether, data on 38,207 deaths were studied and even when full allowance was made for differences in socio-economic status, the sections of the city subjected to heaviest air pollution were areas of maximal deaths from respiratory diseases.

I could not, of course, within the limitations of this talk, cover exhaustively so complex a subject. But even after this brief summary, I feel sure you will agree with the distinguished physicians on the National Conference Health Panel: the evidence that air pollution contributes to the pathogenesis of chronic respiratory disease is indeed overwhelming.

The Federal Role and the New Clean Air Act

I will try to present at least a sketchy idea of the effect on the federal air pollution program of the new Clean Air Act, and then mention some important steps that have already been taken by NTA affiliates in various parts of the country in the interest of clearing the air.

Since the inception of the federal program in 1955, modest but steadily increasing funds have been made available to the Public Health Service for four principal activities in the air pollution field: research, technical assistance to states and communities, training of personnel (for industry as well as for control agencies), and the development and dissemination of information. Under the Clean Air Act, which President Johnson signed into law last December 17th, those activities are retained and expanded, important new ones are added, and the entire program is strengthened by the authorization of substantially increased appropriations.

The expanded program of research and development calls specifically for the development of practical control methods, techniques and prototype devices, also for the development of low-cost methods for removing sulfur from fuel in order to reduce the volume of sulfur dioxide and other sulfur compounds released into the atmosphere. Another important area emphasized is research leading to the development of air quality criteria for the guidance of state and local control agencies in setting up enforceable standards for ambient air quality, and limitations of emissions at the source. The importance of emissions from motor vehicles was again stressed, and the Department is instructed to cooperate with the automotive and motor fuel manufacturing industries in assessing progress and in initiating new research and development efforts toward control of motor vehicle exhaust pollution.

Two wholly new areas of federal action are authorized: financial assistance to states and communities and, in certain circumstances, federal initiative in abatement actions. The Act provides for grants by the Department of Health, Education and Welfare to pay up to two-thirds

of the cost of setting up or improving state and local control programs, and up to three-fourths of the cost in the case of interstate or other regional programs. On interstate air pollution problems, the Department is authorized to hold conferences leading to abatement action. If corrective steps are not taken after such conferences, public hearings can be called and, if necessary, the U. S. Attorney General may be asked to file suit in Federal Court. Similar measures are authorized on intrastate problems, but only at the request of the Governor of the state concerned.

The Clean Air Act authorizes appropriations on a rising scale—an additional $5 million to implement the new program during the present fiscal year, 25 million for fiscal 1965 (which begins July 1), 30 million for fiscal '66, and 35 million for '67.

Secretary Celebrezze and members of his staff are making preparations for implementation of the new Act. Present plans call for putting the major elements of the program in the Public Health Service and in my own Bureau of State Services. The Division of Air Pollution where, as in the past, most federal activities in this field will center, under the leadership of Vernon G. MacKenzie, is one of five in the Environmental Health sector of our Bureau. Mr. MacKenzie feels, as we all do, that we are now, for the first time, in a position to provide nationwide leadership on a scale commensurate with the gravity and growth of this problem. We are beginning to feel that before too many more years have passed, our fight for cleaner air is going to be a winning effort.

The Role of the Voluntary Agency

It has become a truism that actual progress in air pollution control in a given community will go forward no faster than the interest and the desires of the public in that community. That will doubtless continue to be true, regardless of our greater ability today to help any community to help itself. And, in my opinion, it is right here that the experienced voluntary agency can contribute the most, in helping the public to realize the penalties it pays for dirty air and to learn the power to clean the air is in its own hands, if it will only exercise that power.

And I cannot think of better means of moulding public opinion than those which some of your own NTA affiliates have already employed. Three of these which have come to my attention illustrate three different procedures, and all three seem to me to have tremendous potential for good.

Following the publication in the Richmond Times-Dispatch of the series of articles by Hamilton Crockford on air pollution, Woody Wendt, Executive Director of the Virginia Tuberculosis Association, announced June 17, 1961, that his group would work for enactment of state air pollution control legislation which its medical affiliate, the Virginia Thoracic Society, had recommended. In October of that year, the Medical Society of Virginia endorsed the principle of air pollution control. In January, 1962, the U. S. Public Health Service, the Virginia Health Department and the Richmond Air Pollution Control Bureau conducted jointly a study of Richmond's air. I am confident that this snowball, to which your Virginia state affiliate gave such timely impetus, will keep right on rolling.

The New York State Tuberculosis and Respiratory Disease Association, under the able direction of Bob Osborn, is working actively with the State Air Pollution Control Board and Associated Industries of New York State, Incorporated, as co-founders of the New York State Action for Clean Air Committee. The Committee has set up a 10-step program for using existing community resources for air pollution control. These three organizations are working cooperatively to establish Action for Clean Air committees in various communities throughout New York State. Several of these have already been set up and are beginning to operate. Here, I think, is a superb example of what the voluntary agency can do to help abate air pollution and, as a corollary, help to lessen the prevalence and severity of respiratory disease.

In the same state, Mike Plishner, Director of the Queensboro affiliate, is making a special effort to increase public interest in, and understanding of, the air pollution problem in his area. He has recently added to his staff a health educator whose primary efforts will be devoted to the air pollution problem. He has also taken steps to obtain more accurate data on the pollutant levels in Queensboro.

My final example of outstanding accomplishment by an NTA affiliate in an air pollution-related field is provided by the Alabama Tuberculosis Association. This is another instance of close and effective teamwork.

During the course of an on-going statewide survey initiated in 1961, a mobile lung function test unit and new mass screening techniques were developed by the University of Alabama Medical Center and the tuberculosis associations of that state, in cooperation with the U. S. Public Health Service. The project is being paid for by the state affiliate of NTA, headed by K. W. Grimley, Executive Secretary, and no less than 31 local affiliates in Alabama, with support

from a research contract with the Public Health Service. The results of the lung function tests and x-rays are compared with air pollution data and with smoking habits and previous diseases reported by the persons tested. The mobile unit, during its first year, made 10,000 tests in many different sections of the state. The survey will continue for four more years.

Alabama's Congressman Kenneth A. Roberts was so favorably impressed by the facilities and techniques developed in the course of this survey that he invited the Alabama group to bring the mobile unit to Washington for a demonstration. So, during the week ending last July 27th, what the newspapers headlined as an "emphysema test for Congress" was conducted, literally at the foot of the Capitol steps. This demonstration was an unqualified success. Some 300 Senators and Representatives took advantage of this opportunity for a free chest examination.

Public interest ran so high that the occasion was widely reported nationally, in the papers and over the air. Through the participation of Congress, the people were given yet another opportunity to increase their understanding of respiratory disease and its relationship to air pollution and other environmental factors.

I have mentioned only those few of your activities which have come to my attention. I am sure that many others are in progress or in the planning stage in other areas.

All three of my examples have demonstrated in different ways, as your successful campaigns against tuberculosis also have amply demonstrated, that your organization is exceptionally well qualified to contribute to public enlightenment. And there are few areas, if any, in the entire field of public health and welfare, in which public enlightenment is so necessary to real progress as it is in air pollution. That is why we hope that many more of your constituent associations will come to feel as we do, that air pollution offers for your talents a related field, an important field, a worthy field and a highly interesting field.

In closing, I want to suggest that there is a certain poetic justice in the new interest on the part of NTA in air pollution. I learned recently that in England and Wales, at least, the decline in mortality from tuberculosis is being counterbalanced by an increase in mortality from lung cancer. It is highly probable that a similar situation prevails in this country. Several possible cause-and-effect explanations have been advanced for the British phenomenon. But British authorities think it more likely to be simple coincidence. More effective therapy and a rising standard of living, they say, which together have been responsible for the decline in mortality from tuberculosis, have coincided with an increase in cigarette smoking and in urban air pollution.

I think there can no longer be much question as to whether or not tobacco smoke acts as an irritant to the delicate membranes of the respiratory system. Some of the same factors that are identified as harmful in the recent Public Health Service report on "Smoking and Health" are those which we have identified as causing air pollution problems. For example, a Public Health Service study released by the Robert A. Taft Sanitary Engineering Center several years ago indicated that in some cities the quantities of benzpyrene found in the air were such that an individual breathing this air would inhale as much benzpyrene as he would from smoking two or more packages of cigarettes daily. Benzpyrene is of great interest to health authorities because of its possible relationship to lung cancer.

I know that you were convinced even before I spoke to you today that other contaminants in the air we breathe are also harmful to delicate respiratory membranes. Smoking evidently makes lungs more vulnerable to the harmful effects of air pollution. I am sure the reverse also is true and, for the urban smoker, you have, if there ever was one, a vicious circle.

The problem of what to do about smoking is a complicated one. But what to do about total air pollution is even more complex. And air pollution is so widespread in extent, so rapid in growth, and so grave in consequences, that its abatement will require the utmost in cooperative effort from everybody concerned and, as I said before, everybody is concerned. Air pollution is indeed everybody's business. As head of the federal environmental health program, I want to express my firm confidence that many of the constituent associations of NTA will be deeply and actively concerned, also my deep appreciation for that concern.

Postoperative Leukocytosis

Robert L. Bradley, M. D.

TOTAL care of the surgical patient is threefold: (1) preoperative preparation, (2) surgical procedure and (3) postoperative care. Each is equally important in the achievement of a favorable result and each has its criterion. Preoperative evaluation and preparation have become standardized and surgical technique is stressed throughout the surgical training years. Great strides have been made in postoperative care, particularly in the presently growing period of pediatric and geriatric surgery.

The role of electrolytes, vitamins and dietary supplements is well known and tests for evaluating these factors have been standardized. One of the simplest gauges of postsurgical tissue response is the leukocyte count. Because of the paucity of available information on the degree of leukocytosis following common type surgical procedures, operations in 100 consecutive cases were evaluated.

Evaluation in 100 Cases

The patients were followed in chronological order. A preoperative count was obtained on the day prior to surgery and daily thereafter until the sutures were removed and the patient discharged. All counts were made by the same technician, using the electronic cell counter.* In the first 10 cases the count was repeated but on encountering no significant discrepancy, such verification was discontinued thereafter.

All cases in which the initial leukocyte count was higher than 11,000 were omitted, and all in which the postoperative temperature rose to 100 F. or above were discarded; any other obvious sign of infection was a basis for omission.

Nineteen cases of inguinal herniorrhaphy, 22 cases of subtotal gastrectomy and 10 cases of hemorrhoidectomy satisfied the criteria for no complications that had been established beforehand. Leukocyte counts in these cases were evaluated as minimum, median and maximum (Figures 1, 2, 3). The other procedures were too varied and their number too small to merit analysis. It is of interest that the intraperitoneal procedures brought about the greatest leukocytic response. The subtotal gastrectomy cases showed a median count of 14,000 for the first

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*Coulter Counter manufactured by Coulter Electronics, 2525 North Sheffield Avenue, Chicago 14, Illinois.

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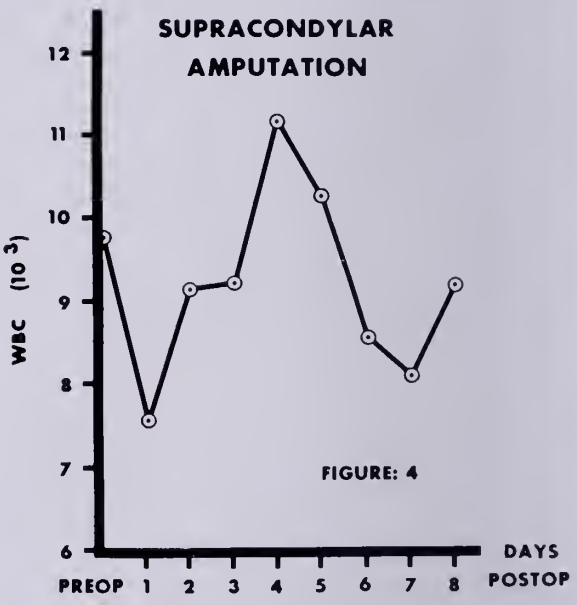
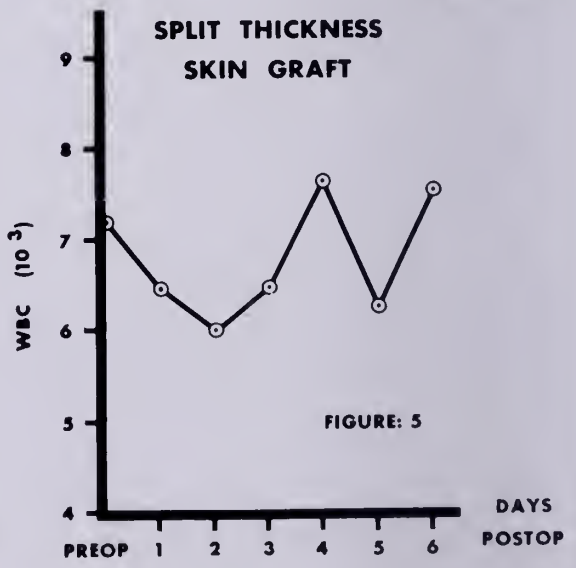




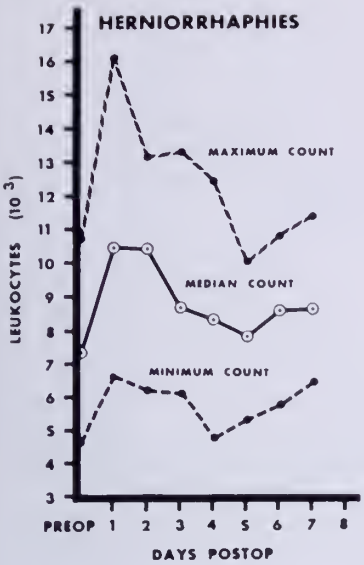
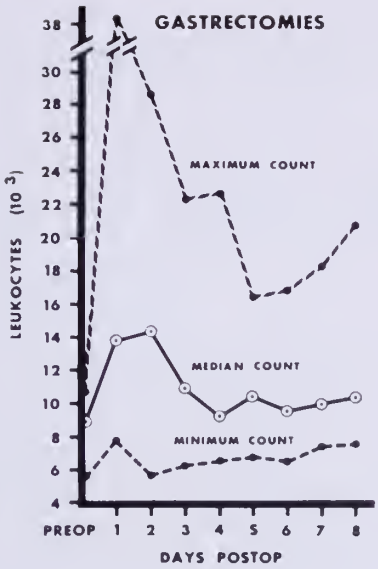


FIGURE: 1



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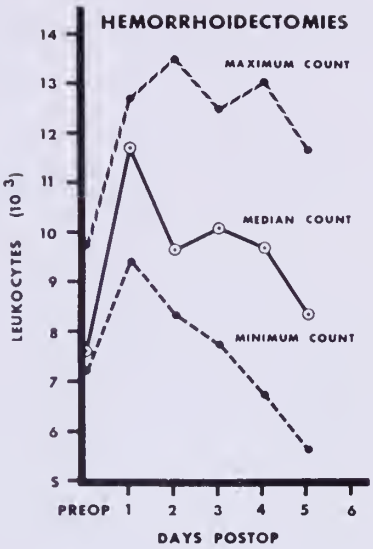

FIGURE: 3

and second postoperative days, with a maximal count of 38,000 in one case. Procedures not involving a visceral cavity showed minimal, if any, leukocytosis postoperatively. As typical procedures evaluation in a case of supracondylar amputation (Figure 4) and in that of a major split thickness of skin graft (Figure 5) are illustrated. There were several cases of resection of lesions of the oral cavity, in none of which was there any significant response. No thoracic procedures were included in the series.

Summary

The leukocytic response is a criterion in the postoperative evaluation of patients. In those cases in which the procedure is carried out in a visceral cavity, there is a tendency to respond with marked leukocytosis, whereas the response from procedures carried out elsewhere in the body shows no significant increase in the leukocyte count, in the absence of complications.

Standards of response for type procedures are given.

Modern Paper Tyranny

THE rapidly increasing volume of paper work required of every practicing physician has just about reached flood proportions. Those of us being submerged by this tidal wave are compelled to insist that ours is a Paper Era rather than an Atomic Age.

Some of the increase is a natural and unavoidable consequence of benefits to the public which have taken place in medical economic fields. Rapid expansion of health insurance has contributed enormously to the work load. However, not all of this burden is necessary, and it has potentialities of diminishing the amount of medical care that a physician can render. Every business executive is aware of the cost of such a burden. Should physicians be saddled with this obligation? Insurance reporting forms have been simplified in recent years but much more drastic action in the same direction is required to avoid the disaster of a deluge.—Westchester Medical Bulletin.

Special Article

Circadian Rhythm and Medicine

Edward J. Van Liere, M. D.

A relatively new term has insinuated itself in the medical literature, namely "circadian rhythm." The term, "circadian," is derived from the Latin, "circa" [=about] + "dies" [=day], that is, about 24 hours. The biologic existence of such a rhythm, although still not understood, has been known for many years. Zoologists have pointed out, for instance, that fruit flies adjust the laying of their eggs to the setting of the sun and, even in captivity, lay their eggs just after dark. The crab times its feeding to the ebb and flow of the sea. Biologists call these rhythms "circadian." It is thought that many life processes occur in rhythms or cycles. Indeed, Halberg, a pioneer worker in the field, and one who has made many contributions to the literature, has stated that organisms evolved on earth represent circadian systems.[4]

Hawking[6] has called attention to the fact that certain human parasites, especially Wuchereria bancrofti, the chief cause of human filariasis and elephantiasis, serve as a good example of circadian rhythm. During the nighttime the microfilaria are numerous in the peripheral blood, but during the day they are scanty or absent. Many other examples of circadian rhythm in lower animals could be cited.

Since so many individuals may suffer some physical and mental inefficiency and lose their sense of well-being from sudden shifts in time phases, Stuhring[7] has emphasized that important meetings and events should not be scheduled until some adaptation has been acquired. The wisdom of this suggestion seems obvious. He suggests, also, that flight crews with short layover times should maintain their home base diurnal cycle.

Circadian Rhythms in Man

Let us now consider the so-called circadian rhythm in man and comment briefly on its clinical significance. There is general agreement that the body has established a physiological rhythm which can be manifested by certain objective findings such as diurnal changes in body temperature, endocrine activity, autonomic tone, electrolyte balance, changes in blood constituents, and other basic changes of metabolism. There is considerable evidence that the metabolic cycle is firmly established, and is normally in phase with the local astronomical cycle.

Submitted to the Publication Committee, April 14, 1964.

The Author

- **Edward J. Van Liere, M. D., Dean Emeritus and Professor of Physiology, West Virginia University School of Medicine, Morgantown.**

Many examples of diurnal rhythm in man can be given and objective proof offered. A common example is the well-known fact that the normal body temperature varies significantly in a 24-hour period, being lowest in the early morning and highest in late afternoon or early evening. Changes have been reported in the number of certain blood cells. For example, Halberg[5] has shown that the number of eosinophiles in the circulation varies during a 24-hour period. They are lowest between the hours of 6:30 A.M. and 9:30 A.M.

Flink and his co-workers[1] observed a definite diurnal variation in the eosinophile count, in the level of 17-hydroxycorticoids, and in urinary 17-hydroxycorticoids, sodium, and potassium excretion. This group[2] has reported also a diurnal variation in magnesium and creatinine excretion in the urine in normal subjects. Many other examples of diurnal variation could be given, but these will suffice.

Symptoms Produced by Rapid Time Displacement

The symptoms produced by sudden changes in time shifts are more or less indefinite and are subjective in nature. Many persons lose their mental and physical efficiency. The subjects complain of lassitude and fatigue, and state that they feel below par. Dr. James E. Crane, internist of Springfield, Connecticut, has called attention to the effects of long, high-speed flights

which involve the crossing of several time zones. He describes a condition which he has termed, "time zone fatigue syndrome." He has reported that the effects of this "time zone fatigue syndrome" have been noted in actors, chess players, athletes and even in race horses. He has stated, further, that jet pilots complain of fatigue, aging and tension.

It is likely that some individuals, even those in normal health, are much more affected than others. It may be, too, that older persons find it more difficult to adjust to these sudden time changes than those who are younger. To my knowledge, however, this has not been reported in the literature.

It is probable that individuals not in robust health might be seriously affected by sudden time changes. Stuhring[7] has pointed out the significance of a pronounced phase shift to patients who require precise scheduling in their drug therapy such as diabetics, epileptics, cardiacs and ulcer patients. The importance of this is obvious. Sufferers from periodic migraine, who are apt to lead (often perforce) a rather quiet and routinized existence, doubtless would be noticeably affected by sudden shifts in time phases.

Airplane Flights and Circadian Rhythm

The matter of circadian rhythm has assumed more importance due to widespread airplane travel. It will become even more momentous when supersonic planes are widely used. Stuhring[7] recently has called attention to this, and offers a concrete example. He calls attention to the fact that there is a phase shift of nine hours between Los Angeles and Rome. The distance is 5,500 nautical miles; by supersonic flight the total trip times between these two cities would be only five hours. If a passenger left Los Angeles at 8:00 A.M., upon his arrival in Rome his watch would indicate 1:00 P.M. (assuming that he did not change his watch en route). Actually, the time in Rome would be 10:00 P.M.; this is well past the usual dinner hour and, indeed, not far from bedtime. Stuhring states that it takes at least a full week before our metabolic clock and the local clock are again in phase.

As to the time it takes the body to recover from a pronounced phase shift, it is of interest to cite the work of Flink and Doe.[3] These workers, in 1959, reported on the effect of sudden time displacement by air travel on synchronization of adrenal function. They measured the excretion of 17-hydroxycorticosteroids in the urine at frequent intervals throughout 30 hours at five different times following a shift from Central Standard Time (Minneapolis, Minn.) to Japan and Korean time. The time displacement was approximately nine hours. The 17-hydroxycorticosteroids excretion became synchronized with the new time schedule in nine days. The same was true of potassium and sodium excretion.

Value of Gradual Shifting of Time Phase

A phase shifting of circadian rhythm can be brought about without discomfort to the subject if the change is made gradually. This may be difficult to accomplish for workers in industries such as mines or factories. When these individuals, who are accustomed to work during the day, are summarily put on a night shift, doubtless a number of days elapse before they recover their normal metabolic equilibrium.

It would be helpful if a more gradual change could be brought about, because it is known that a certain amount of time is needed for readjustment. It might be possible to set up a working schedule, for example, from 4:00 P.M. to 12:00 P.M. and after a certain period arrange for later working hours. It is appreciated that this might not always be feasible in industry.

An example of a gradual change in circadian rhythm is that of travelers on a transcontinental train. Such a trip takes somewhat less than three days. The gentle time changes cause no inconvenience to the passengers. This applies also to people who travel across the continent by automobile. In contrast to these two methods of travel, the jet airplane can span the continent within a few hours. During a flight, for example, from New York to San Francisco, the plane passes through four time zones; such a rapid journey is distinctly capable of upsetting the circadian rhythm.

Summary

In summary, most persons, if not all, are affected to some degree by sudden time displacement, such as produced by airplane travel. It has been shown that a rapid shift of time of four hours (or more) produces objective changes in bodily processes. Physical and mental efficiency is impaired and the subject complains of a loss of the sense of well-being. It may take several days for some persons to recover from a sudden time change. If the time change is nine hours (or more), it takes approximately seven days for the body to adjust itself to the new time phase. Due to these bodily changes produced by sudden time shifts, obviously, important meetings or events should not be scheduled until some degree of adaptation has been acquired.

A list of references may be obtained by writing the author.

The President's Page

THE ELECTION AND THANKSGIVING

All that is necessary for the triumph of evil is that good men do nothing."—Edmund Burke

In this month of Thanksgiving, let us first continue to work hard to insure the election of those candidates dedicated to the principles of good government, upholding our Constitution, and who will not lead us down the road to Socialism. The votes that are cast by you, your family, friends, and especially your patients in a few days may help decide the most crucial election of this century. I urge you to continue your activities down to the last minutes of this campaign.

At this Thanksgiving we can look back and be thankful for:

- The tremendous medical research of our many colleagues which has given us 18 million people living over 65 today, who have a longevity of 15 additional years; whereas, at the turn of the century only 3 million of that age group were living.

- For the Drs. Salk and Sabin and Drs. Flemings and Henderson and many others in medicine, who gave us the polio vaccines, the steroids and chemotherapy to cut down fetal mortality, serious illnesses and virtually wiped out some contagious diseases.

- For the love and devotion that is intrinsic in most every physician as he gives up many of his leisure hours for the unselfish and unpublicized devotion to charity, the clinics, civic endeavors, medical research and additional study so that he may be better able to care for his patients.

Yes, we in medicine today have much for which we can be thankful. A compassion and love for our profession and the highest standards of medical practice found anywhere in the world. This is attested to by our colleagues from the many countries engulfed by Socialized Medicine, who have flocked to our shores telling loudly and well, how precious is this, our freedom in the type of medicine practiced in these United States today. Let us try harder to keep it that way.

"Almighty God in your infinite ways, we are truly thankful, Amen."

Albert C. Esposito

Albert C. Esposito, M. D., President

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EDITORIALS

TUBERCULIN TEST IS A GOOD TEST

The tuberculin test is a good test. It should be used more in tuberculosis control. This test becomes more and more valuable each year in pinpointing tuberculosis if we believe that less and less people are infected with the tubercle bacillus. Let's use the tuberculin test.

It would be nice to stop this message on these positive statements but unfortunately the negative statements regarding the tuberculin reaction have been emphasized so strongly that we must continue writing. Even the Report to the Surgeon General of the U. S. Public Health Service by a Task Force on Tuberculosis Control bewails the imperfections of the tuberculin test and hopes for a blood test to determine not only presence but activity of tuberculosis. No one can argue against the refinement of any clinical test; but, non-specific reactions are certainly to be expected from most allergens, and, tuberculin is no exception. It is a known fact that tuberculin will give false positive reactions to other acid-fast bacilli. Practically, I can't see that it makes a bit of difference if these few patients *are* identified as positive tuberculin reactors and kept under supervision along with the true tuberculin reactors.

Why has the negative image of serological testing for syphilis never been emphasized as with tuberculin testing? At the desk in the clinic of our local health department is a note listing the percentage of false positive reactions with serology tests for syphilis: malaria, 100 per cent; leprosy, 60 per cent; relapsing fever, 30 per cent; active immunizations in children (pertussis, diphtheria and tetanus), infectious mononucleosis, atypical pneumonia, rat bite fever, typhus and vaccinia, 20 per cent; and, infectious hepatitis, leptospirosis, periarteritis and trypanosomiasis, 10 per cent. A Wasserman or other serology test, as done routinely, doesn't tell whether syphilis is active or latent. It doesn't tell whether latent disease will later become active. Often the positive serology persists in spite of the most extensive therapy, but this doesn't necessarily denote immunity to a new syphilitic infection. Yet in spite of these imperfections the blood serology is the positive test for syphilis, required on all hospital admissions, for food handling permits, barber and beautician licenses, and even for marriage certificates. Would that we had as firm and positive approach to tuberculin testing.

A shady reputation is difficult to overcome. Tuberculin was accused of being inadequate because people with negative reactions had calcium deposits on lung x-rays. All calcium was thought to be evidence of tuberculosis infection, hence tuberculin was useless. This idea has certainly changed with the discovery that calcium can result after histoplasmosis and other diseases. Tuberculin was inadequate because people with sputum positive for the tubercle bacilli had neg-

ative tuberculin reactions. These people had such poor resistance that there was complete anergy and naturally no allergic response to tuberculin. Tuberculin injections were accused of causing spread or flare-up of tuberculous lesions. This can no longer be an objection with the tuberculin used at present. Finally, what was the use of doing tuberculin when practically all adults gave positive reactions as a result of having been infected with the tubercle bacillus? I am constantly amazed at the number of patients I see referred to a public health clinic primarily for the supervision of tuberculosis with negative tuberculin tests, in spite of x-ray findings strongly resembling either acute or chronic tuberculosis. It has become a very valuable tool for keeping these people out of a sanatorium.

Even as continued efforts have been made to refine the original Wasserman, let's not discourage the efforts being made to improve the material used, the method of testing and the interpretation of tuberculin tests. *But*, let's not wait for the improved technique but use this valuable test that is now available to find people infected with tubercle bacilli.

The tuberculin test is a good test. It should be used more in private practice and we should see that the recommendations of the Task Force on Tuberculosis Control to tuberculin test all children at first entrance to school, all school teachers and other school employees, and all 14-year-olds in school be carried out promptly.

CARBON MONOXIDE POISONING

With the advent of autumn and winter it is meet to call attention again to the danger of carbon monoxide poisoning. Although it is true there is virtually no carbon monoxide in West Virginia natural gas, nevertheless, it may be found if combustion is not adequate. Accidental carbon monoxide poisoning due to poorly adjusted gas heaters is not infrequently reported.

Despite the many warnings concerning the extreme danger of carbon monoxide poisoning there are people who still start their cars as a "warming up process" in closed garages. The results are often fatal to the occupants of the car. Since the exhaust from the average automobile contains from 0.5 to 15 per cent carbon monoxide (depending upon the efficiency of the engine) it is obvious that the air in the closed garage would soon contain a dangerous concentration of carbon monoxide.

Because carbon monoxide hemoglobin is a relatively stable compound compared to oxyhemoglobin, even a concentration of less than 0.1 per cent in the ambient air can, after a time, produce disagreeable symptoms such as, lethargy and headache. Some people apparently are more susceptible to carbon monoxide than others. Roughly speaking headache may be produced when 30 to 40 per cent of the hemoglobin is saturated by carbon monoxide; unconsciousness intervenes with a saturation of 50 to 60 per cent, and a saturation of 75 per cent is usually fatal.

In the event of carbon monoxide poisoning the patient should, of course, be removed from the dangerous atmosphere immediately so that he may breathe fresh air. Often this is not enough as has recently been pointed out by Zorn.[1] He writes that depending upon the condition of the patient, treatment may vary from mouth-to-mouth breathing to high pressure oxygen respiration. He emphasizes that even patients with mild carbon monoxide intoxication require treatment because oxygen therapy prevents or lessens sequelae. Zorn mentions further that often hypothermia develops in severe cases of carbon monoxide poisoning. It is important to keep the patient warm, although care should be taken not to supply additional heat, because this stimulates the circulation and causes an increase in oxygen requirements.

The matter of treatment of carbon monoxide poisoning by administration of oxygen at high atmospheric pressure is worthy of comment. Sluijter[2] recently has written that excellent results were obtained in patients who were conscious or lightly comatose. Less favorable results were obtained in a group of patients who were in deep coma, and who had some degree of hypotension and some neurological abnormalities. In essence, he concluded that the administration of high pressure oxygen may be effective in two ways: (a) If it can be started immediately, it restores the oxygen transport function of the blood, and (b) It combats the secondary hypoxia which may have developed as a result of cerebral swelling. It is recognized, of course, that facilities are seldom available to administer hyperbaric oxygenation. In the not far distant future, however, such facilities may be available in various sections of the State.

The great danger in carbon monoxide poisoning is that it may damage the central nervous system. It is known that nervous tissue is the least capable of withstanding oxygen want. An individual who has been exposed to carbon monoxide poisoning may suffer irreparable changes to the central nervous system. He may show

grave changes in his personality, or as Drinker[3] has pointed out may be practically decerebrated. Such a person may lead a vegetative existence the remainder of his life. Actually he does not live, but merely exists. It is extremely important, then, that carbon monoxide poisoning be treated promptly and efficiently the moment the condition is recognized. But equally important, every known precaution should be used to avoid carbon monoxide poisoning.

Safety precautions taken by the drug industry are frequently even more stringent than required: As an example, the strength and purity of drugs produced by the reputable prescription drug manufacturers generally are higher than the already stringent standards established by the U. S. Government or by official bodies authorized by law.

1. Zorn, H. Muenchen Med. Wschr. 106:235, 1964.
2. Sluijter, M. E. Proc. Roy. Soc. Med. 56:1002, 1963.
3. Drinker, C. K. Carbon Monoxide Asphyxia, P. 133, New York: Oxford University Press, 1938.

WHAT IS AN EXTERN?

The Dorland Medical Dictionary defines an "extern" as a senior medical student or graduate in medicine who assists in the care of patients but does not reside in the hospital. Other medical facilities supply different definitions and relate the term to their particular need at a particular time. Generally speaking, the term is now most generally applied to a medical student who is accepting employment from a hospital for clinical or laboratory work having no connection with the curriculum pertaining to the year in which he is registered in the medical school and consequently "the medical school usually takes no responsibility for the externship since this is not a part of the curriculum."

Throughout the land it has become the custom for all medical student externs in hospital practice to "cover" for hospital staff or visiting staff. This practice has reached proportions that have caused alarm in medical and hospital circles.

There has always been some question concerning the legal responsibility of the extern's practice and with an increasing sensitivity of public and patient to medical liability the problem requires direct and arbitrary solution. Pennsylvania does not permit extern medical service anywhere.

The American Hospital Association, pursuant to an opinion on the legal aspects of externship, advised member hospitals employing externs to give consideration to: (1) Checking upon adequacy of hospital liability insurance coverage; (2) cautioning members of the medical staff who supervise externs to look into the pertinent adequacy of their professional liability insurance, and (3) obtaining insurance to protect the extern against potential personal liability.

Recently the Medical Licensing Board of West Virginia received the following request from Clark K. Sleeth, M. D., Dean of the West Virginia School of Medicine: "We would much appreciate your guidance in formulating a set of instructions for any of our students who might be employed in such a relationship (externship). We note that a recent action has been taken by the Pennsylvania State Licensing body which defines the externship without direct and immediate supervision as unlicensed practice of medicine."

To this, N. H. Dyer, M. D., Secretary of the Medical Licensing Board of West Virginia replied: "After consideration the Medical Licensing Board wishes to advise that it is the opinion of the Board that no hospital service may be undertaken by the externs unless they are under the supervision of a licensed physician and that the physician must be present at the time and place when the student renders the service."

This ruling was brought to the attention of all second, third and fourth year medical students by endorsement.

The use of medical students by physicians and hospitals in West Virginia should fall within these limits of supervision; otherwise, grave liability may result to any of the involved parties through the unlicensed practice of medicine.

Serious Issues in Clinical Research

Several high courts, upon review of appeals from the lower courts, now say that the physician owes it as a duty to his patient to make a reasonable disclosure of the risks involved (in clinical research) so that the patient can arrive at an intelligent and informed decision. Failure on the part of the physician to do this, the courts further note, constitutes malpractice in his community.

This brings up certain difficulties for the physician, since the courts did not specifically define what they meant by an informed consent. Must a physician lay before the patient a complete monograph on his procedure? Must he tell him of 100 per cent of complications? Of 80 per cent? Of 50 per cent? Or must he tell him about the major hazards only and skip the minor ones? With investigative work the problem is compounded. For those of you who are doing such investigation dealing with patients, I can only emphasize the serious issues with which you are presently faced in embarking upon clinical research. — Joseph J. Sadusk, Jr., M.D., in Medical Annals of the District of Columbia.

GENERAL NEWS

303 Attend Rural Health Conference At Jackson's Mill on Oct. 1

The 17th Annual Rural Health Conference, held at Jackson's Mill on October 1, was enthusiastically received by the 303 persons who attended.

The attendance established a new record for the conference, exceeding by 45 the previous high of 258 in both 1958 and 1963 at the State 4-H Camp. The 1962 Conference at the West Virginia University Medical Center in Morgantown attracted 242 persons.

The one-day meeting was divided into four segments—"Medical Quackery," the "Immunization Program in West Virginia," "Living with Your Disability," and "Medicine and Religion."

Dr. Albert C. Esposito of Huntington, right, President of the State Medical Association, is shown with Dr. Paul A. Miller, President of West Virginia University, at the 17th Annual Rural Health Conference at Jackson's Mill on October 1. Doctor Miller was the keynote speaker for the meeting which drew 303 persons.

The West Virginia State Medical Association sponsors the conference annually under the auspices of its Rural Health Committee, with the full cooperation of the West Virginia Home Demonstration Council, the West Virginia Farm Bureau, the State Department of Health, the West Virginia Congress of Agriculture, and the Agricultural Extension Service of West Virginia University.

Doctor Fisher Presiding Officer

Dr. Earl L. Fisher of Gassaway, the presiding officer, called the meeting to order at 10 A. M. The invocation was given by the Rev. H. Edgar Suite, Pastor of the Gassaway Methodist Church.

Dr. Paul A. Miller, President of West Virginia University and a former county agricultural agent in Ritchie and Nicholas counties, presented the keynote address.

Mr. James L. Trawick of Washington, D. C., Mr. Harold Mauldin of Atlanta, Georgia, and Dr. L. A. Dickerson of Charleston were the other morning speakers

Dr. Albert C. Esposito of Huntington, President of the West Virginia State Medical Association, delivered an address of welcome at the opening of the afternoon session.

Dr. Marilyn A. Jarvis of Morgantown, Dr. Tracy N. Spencer, Jr., of South Charleston, the Rev. John S. Lyles of Dunbar and Dr. Bond L. Bible of Chicago were the other afternoon speakers.

'Medical Quackery'

Mr. Trawick, Director of the Division of Consumer Education of the U. S. Food and Drug Administration, gave an interesting talk and slide presentation on the many items produced for sale to the American public by "Medical Quacks."

"When we talk about quackery today, we are talking not only about the fake medical practitioner with the phony diploma," he said, "we are also talking about the use of false or misleading information either to sell a health product or service, or to create a climate or knowledge and attitude which will help sell the product later.

"We are talking about food faddism and nutritional mis-information; about pseudo-science in books and magazines; about weight-reducing gimmicks and unproved theories about cholesterol and unsaturated fats in the diet; and about worthless and sometimes dangerous medicines and medical devices."

Mr. Trawick said that certain basic knowledge and attitudes about health must be established before the individual reaches maturity and is faced with what might be a life-or-death decision.

'Immunization Program'

Mr. Mauldin, Chief Public Health Advisor for Immunization Activities at the Communicable Disease Center in Atlanta, and Doctor Dickerson, Director of the Disease Control Division of the State Department of Health, discussed the methods being used in the current program for immunization in West Virginia.

The Department of Health also had an exhibit explaining the program and State Director of Health Dr. N. H. Dyer urged the cooperation of all West Virginians in this program.

Address by Dr. Albert C. Esposito

Dr. Albert C. Esposito of Huntington, President of the State Medical Association, was introduced by Doctor Fisher and delivered a short address of welcome at the opening of the afternoon session.

He said that the medical profession in West Virginia looks upon the Rural Health Conference as a very important part of its annual program and has a great interest in the problems of the state's rural population and their solution.

"With only 38 per cent of our people living in the cities, we hope that more of the students from the rural areas will consider a career in medicine. With the completion of our four-year School of Medicine and the first graduates now coming forth, we need your sons and daughters to join us in the love and devotion to human miseries that is medicine."

'Living With Your Disability'

Doctor Jarvis, Research Associate in the Division of Public Health and Preventive Medicine at the West Virginia University School of Medicine, described the many ways individuals can lead useful lives though hampered by a disability.

'Medicine and Religion'

Doctor Spencer, Chairman of the State Medical Association's Committee on Medicine and Religion, described briefly the origin of the program at both the national and state levels.

Rev. Lyles described the chaplaincy program conducted at the Herbert J. Thomas Memorial Hospital in South Charleston for the past several years and the many benefits that have been derived from it.

There also was a presentation of the film, "The One Who Heals," during this portion of the program.

Doctor Bible, Secretary of the Council on Rural Health of the American Medical Association, presented a summary of the meeting in which he praised West Virginians for their industry and spirit.

Dr. Marilyn A. Jarvis and the Rev. John S. Lyles of Dunbar, left, and Dr. Tracy N. Spencer, Jr., of South Charleston, were among the speakers at the one-day meeting. Doctor Jarvis, a Research Associate at the West Virginia University School of Medicine, presented a paper on "Living With Your Disability." Rev. Lyles and Doctor Spencer discussed the program on Medicine and Religion sponsored by the State Medical Association.

Pamphlets on Mental Retardation Available to Physicians

Three new pamphlets on mental retardation have been published by the Joseph P. Kennedy, Jr., Foundation and are available to physicians and other interested persons.

The following pamphlets, written in simple informative language and designed to be of help to expectant mothers, parents, and other persons who work with children, are available upon request: "Expectant Mothers: What You Should Know," "Education for the Mentally Retarded," and "Recreation for the Mentally Retarded."

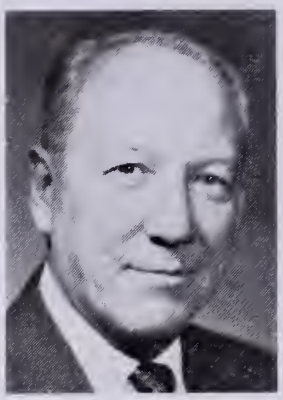
Copies of the pamphlets may be obtained by writing the Joseph P. Kennedy, Jr., Foundation, 1411 K Street, N. W., Washington, D. C.

Miss Gertrude Humphreys of Morgantown, State Extension Home Demonstration Leader, is shown with Dr. Bond Bible of Chicago, and Dr. Clark K. Sleeth, Dean of the West Virginia University School of Medicine, during a break in the Rural Health Conference. Doctor Bible, a former instructor at WVU and now secretary of the AMA's Council on Rural Health, summarized the proceedings at the conclusion of the afternoon session.

In the other picture, Dr. Earl L. Fisher of Gassaway, center, the presiding officer, is shown with the Rev. H. Edgar Suite of Gassaway, who gave the invocation, and Mr. Harley V. Cutlip, Director of the State 4-H Camp.

18th Annual AMA Clinical Meeting Planned in Miami Beach

Dr. Donovan F. Ward of Dubuque, Iowa, President of the American Medical Association, will preside at the 18th Clinical Convention which will be held in Miami Beach, November 29-December 2.



Donovan F. Ward, M. D.

Doctor Ward, who assumed the duties of president following the sudden death of Dr. Norman A. Welch, has practiced his specialty of surgery in Dubuque since 1931 with the exception of four years during World War II when he served with the Medical Corps of the U. S. Navy. He is currently serving as Chief of the Surgical Section of Finley Hospital in Dubuque, and as Senior Surgeon at Mercy Hospital and Consulting Surgeon at Xavier Hospital.

Doctor Ward served for several years as a delegate from Iowa and was named vice-president of the AMA in 1963, and president-elect in 1964.

Drs. Frank J. Holroyd of Princeton and C. A. Hoffman of Huntington are the official delegates from the West Virginia State Medical Association and will attend all sessions of the House of Delegates. Drs. Thomas G. Reed of Charleston and D. E. Greeneltch of Wheeling are the alternate delegates.

Interesting Scientific Program Arranged

A scientific program attuned to the current needs and interests of the practicing physician has been planned for the meeting. General registration, nearly all scientific sessions and scientific and industrial exhibits will be held in Miami Beach Convention Hall.

Course for General Practitioners

More than 300 physicians will participate in the scientific program and a new feature this year will be a postgraduate course on "Obstetrics for the General Practitioner." Fifteen lectures will be presented during three sessions ranging from infertility and prenatal care through complications of labor and anesthesia to postnatal care for maternal mortality.

The popular fireside conferences, sponsored jointly by the American College of Chest Physicians and the AMA, will be held on Sunday night, November 29. There will be eleven tables and more than 50 discussion leaders will engage in an informal and free exchange of views on a variety of medical subjects.

The Sixth National Conference on Medical Aspects of Sports will be held on Sunday, November 29. Dr. Thomas B. Quigley of Boston will preside at the one-day meeting.

The complete scientific program for the meeting was published in the October 26 issue of the JAMA.

Revised Hill-Burton Act Provides For Moderization of Facilities

The recently revised Hill-Burton Act assures continuation of the program for aid to hospitals and health facilities and expands provisions to meet current needs during the next five years. State Health Director Dr. N. H. Dyer, in his weekly State of the State's Health, discussed the revised Act and how these changes will affect West Virginia.

It was pointed out that under the former act, provisions were made for construction of new health facilities and the construction of new additions to already standing structures. Under the expanded program modernization of existing facilities will be possible. Funds totaling $160 million over a four year period have been appropriated for modernization throughout the nation. The act permits appropriations of $20 million for 1966, $35 million for 1967, $50 million for 1968 and $55 million for 1969. These funds can be utilized for alterations, major repairs, remodeling, replacement, renovations and equipment. Considerable study will be necessary to fully evaluate West Virginia's existing institutions, some of which have grown functionally and structurally obsolete.

The revised version of the Hill-Burton Act will also offer financial aid in administering the program. The new legislation provides that a state may use up to 2 per cent of its annual construction allotment or $50,000 (whichever is less) to pay for as much as half of the cost of administering the state plan. In order to prevent states from substituting federal funds foi state funds, 1964 has been set up as a base line and no state can use less state money than in that year. It will be increasingly important for state appropriations to be continued in order to take advantage of the massive funds available.

Another change in the program provides for the establishment of "Long Term Care Facilities" category. This combines the previously separate programs for chronic disease hospitals and nursing homes.

Although actual appropriations have not been approved, the request is based on a total of $220 million for the nation. Since this is the same figure used last year, it is estimated that West Virginia will receive a total of $3,075,152. The state has already claimed $37,708,411 since the inception of the program in 1946.

Dr. C. A. Hoffman Participates In AMA Conference

Dr. C. A. Hoffman of Huntington participated in the Fourth National Congress on Voluntary Health Insurance and prepayment which was held in Las Vegas, Nevada, October 2-3.

The two-day meeting was sponsored by the American Medical Association's Council on Medical Service and Committee on Insurance and Prepayment.

Doctor Hoffman, who is a member of the Committee on Insurance and Prepayment plans, served as moderator for a discussion group and the panelists included representatives of managment, labor and other interested groups.

12th Annual Bluefield Sanitarium Seminar Held on October 1

The 12th Annual Medical Seminar, sponsored by the Bluefield Sanitarium, Stevens Clinic Hospital and the Clinch Valley Clinic, was held at the Bluefield Country Club in Bluefield on October 1.

A scientific session was held in the afternoon and a reception and banquet that evening. Speakers for the scientific session and their subjects were as follows:

"The Practical Aspects of Scintiscanning."—Richard O. Rogers, Jr., M.D., Department of Internal Medicine, Bluefield Sanitarium.

"Clinical Applications of Cinefluorography in Roentgen Diagnosis."—George C. Barrett, M.D., Section of Radiology, Emory University Clinic, Atlanta, Georgia.

"Trends Toward Automation in the Clinical Laboratory."—David F. Bell, Jr., M.D., and John J. Bryan, M.D., Department of Laboratories, Bluefield Sanitarium.

"Electronic Computer Uses in Private Hospitals."—John E. Gustafson, M.D., Iowa Methodist Hospital and Raymond Blank Memorial Hospital for Children, Des Moines.

The speaker at the banquet was Mr. W. Thomas Rice of Jacksonville, Florida, President of Atlantic Coastline Railroad. His subject was "Railroading in the Southeast."

Regional GP Symposium Held In Logan on September 13

A Symposium on Pulmonary Diseases and Heart Ailments, sponsored by the West Virginia Chapter of the American Academy of General Practice with the cooperation of Eli Lilly and Company, was held at the Appalachian Auditorium in Logan on September 13.

Two members of the faculty of the West Virginia University School of Medicine presented papers during the scientific session.

The speakers and their subjects were as follows:

Charles E. Andrews, M. D., Professor of Medicine, "The Management of Chronic Obstructive Disease of the Lung," and "Diagnostic Techniques in Pulmonary Diseases."

A. C. Edmundowicz, M. D., Assistant Professor of Medicine, "The Treatment of an Acute Myocardial Infarction," and "The Management of Cardiac Arrhythmias."

Dr. Peter A. Haley of Charleston, President of the West Virginia Chapter, AAGP, introduced the speakers. Dr. Ray M. Kessel of Logan served as chairman of the program committee.

'30th' Anniversary

The Physicians and Dentists Business Bureau Inc., of Huntington, will celebrate the "30th" anniversary of its establishment by holding an open house on Tuesday, November 24.

The bureau, which is an affiliate of the Medical-Dental-Hospital Bureaus of America, is operated by Hal and Truly Herbert.

Dr. Bernard Zimmermann New President Of W. Va. Cancer Society

Dr. Bernard Zimmermann of Morgantown was elected president of the West Virginia Division of the American Cancer Society during the annual meeting of that organization which was held at Blackwater Falls, September 11-13.

Bernard Zimmermann, M. D.

Doctor Zimmermann, Professor and Chairman of Surgery at West Virginia University School of Medicine, succeeds Dr. John C. Condry of Charleston.

Dr. W. E. Copenhaver of Bluefield was elected vice president, Miss Marjorie Scott of Wheeling, secretary, and Max Saunders of Charleston, treasurer. Mrs. D. N. Thomas of Weirton was named chairman of the State Executive Committee.

New members elected to the board of directors were as follows:

William W. Conklin and Dr. Hugh H. Cook, Jr., Elkins; Dr. Paul E. Prillaman, Jr., Ronceverte; Dr. E. R. Chillag, Holden; Norris Kantor, Bluefield; and Maxwell S. Roth, Huntington.

Reelected to the board were Mrs. W. W. Barron, Charleston; Dr. Jack M. Burnett, Wheeling; Dr. John L. Campbell, Morgantown; Dr. L. Walter Fix, Martinsburg; Dr. Rex Dauphin, Parkersburg; Dr. James P. Carey, Huntington; Dr. David B. Gray, Charleston; Dr. W. E. Copenhaver, Bluefield; W. T. Brotherton, Charleston; Mrs. D. N. Thomas, Weirton; Chapman Revercomb and Max Saunders, Charleston; and Albert Tieche, Beckley.

Dr. Murray M. Copeland, president elect of the American Cancer Society, was the principal speaker at the three-day meeting. Mr. William D. Gargan, nationally known entertainer before undergoing a laryngectomy, was also a guest speaker.

Medical Meetings, 1964-65

The following is a partial list of national, state and district medical meetings scheduled for 1964-65:

1964

Nov. 9-12—Interstate PG Assn., Pittsburgh.
Nov. 16-19—Southern Medical, Memphis, Tenn.
Nov. 29-Dec. 2—AMA Clinical Meeting, Miami Beach.

1965

March 26-27—National Rural Health Conference, Miami Beach.
April 30-May 2—W. Va. Chapter, AAGP, Wheeling.
May 9-14—Ohio State Medical Assn., Columbus.
May 30-June 2—National TB Assn., Chicago.
June 20-24—AMA Annual Meeting, New York.
Aug. 26-28—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 18-26—Pennsylvania Medical Society, Atlantic City.

Dr. Albert C. Esposito of Huntington, second from left, President of the State Medical Association, was the guest speaker at the annual joint meeting of the Central West Virginia Medical Society and Auxiliary in Buckhannon on September 30. He is shown with Dr. Robert L. Chamberlain of Buckhannon, Dr. John E. Echols of Richwood and Dr. J. C. Huffman of Buckhannon. Dr. Ira F. Hartman of Buckhannon was elected president succeeding Dr. Donald S. Groves of Summersville. Dr. Charles T. Lively of Weston was named vice president and Doctor Chamberlain re-elected secretary.

58th Southern Medical Assn. Meeting In Memphis, November 16-19

Several West Virginia physicians will participate in the scientific sessions planned in connection with the 58th Annual Meeting of the Southern Medical Association which will be held at the Ellis Municipal Auditorium in Memphis, Tennessee, November 16-19.

Dr. Albert C. Esposito of Huntington, President of the West Virginia State Medical Association, will represent West Virginia as Councilor at the four-day meeting.

Doctor Esposito also is Chairman of the Section on Ophthalmology and will present a paper on "The Role of General Anesthesia in Cataract Surgery" before the Section on Tuesday afternoon, November 17, at Ellis Municipal Auditorium.

Dr. H. Charles Ballou of White Sulphur Springs serves as Chairman Elect of the Section on Industrial Medicine and Surgery.

Dr. S. D. Wu of Philippi will present a paper on "Contemporary, Multiple Major Diseases" before the Section on Pathology at 9:45 A. M. on Monday, November 16, in Ellis Municipal Auditorium.

Drs. Michael M. Klein and Robert L. Bradley of the Huntington VA Hospital will present a paper on "Gastrospasm in Gastric Ulcer" at the same hour before the Section on Radiology. They will also have an exhibit on "Gastrospasm in Gastric Ulcer Simulating Carcinoma."

Symposia Highlight Sessions

Three special symposia will be presented covering a variety of subjects, offering postgraduate education in the most modern form.

A Symposium on Drug Therapy, Clinical Pharmacology and Reaction to Drugs in Hospital and Office will be held on Monday, November 16. It will relate to drugs as they are used in the practice of medicine. Four nationally-known speakers will discuss various aspects of drugs, drug safety, drug toxicity, and clinical pharmacology as it relates to hospitalized and out patients.

A Symposium on Current VD Problems will be held on Wednesday, November 18. Venereal disease has again become a major health problem which deserves attention. This symposium will bring up-to-date information on diagnosis, treatment and epidemiology of venereal disease by a panel of experts.

A Symposium on the Problems of Adolescents will be held on Thursday, November 19. A panel will discuss their problems of gynecology, dermatology, the family problems, problems of an orthopedic nature, tobacco and bad habits, problems with the law, and psychiatry as it works out the problems of the adolescent mind.

Dr. Robert D. Moreton of Ft. Worth, Texas, is president of the Southern Medical Association. The president elect is Dr. R. H. Kampmeier of Nashville, Tennessee.

The 40th annual meeting of the Auxiliary will be held in conjunction with the meeting of the Association. Mrs. Ross P. Daniel of Beckley is the Southern Medical Councilor from West Virginia.

Epidemic Year for German Measles

Recent figures compiled by the National Disease and Therapeutic Index, which is a nationwide survey of private medical practice, show that visits for German measles reached epidemic proportions in the first six months of 1964.

The survey, which measures the number of patient-physician contacts involving various diagnoses, estimated that physicians received over 1.8 million visits for rubella through last June. This represents a 500 per cent increase over the first six months of 1963.

The West Virginia Medical Journal

December, 1964 Vol. 60, No. 12

Islet Cell Tumors of the Pancreas*

(With Case Report)

H. Carl Wasson, Jr., M. D., F. L. Coffey, M. D., and G. F. Woelfel, M. D.

Langerhans,[3] in 1869, first described the pancreatic islets. Nichols, in 1902, described the islet cells. Insulin was "isolated" in 1922 and Harris, in 1924, described the concept of hyperinsulinism.[1,3] Wilder and Mayo,[1] in 1927, established the correlation between hyperinsulinism and islet cell tumors of the pancreas. Graham,[1,3] in 1929, effected the first surgical cure by excision of a functioning islet cell adenoma. Since that time many case reports have been added to the literature. Howard, Moss and Rhodes,[1,3] in 1958, reviewed the 765 recorded cases, of which number 50 per cent had been reported during the previous ten years. Since then, case reports continue to appear sporadically in the literature. No one surgeon nor clinic has been able to report a large series of cases because of the rarity of the condition. Nevertheless, we feel that constant alertness for this clinical entity is indicated since the results of surgical correction are dramatic and gratifying. This physiologic tumor may occur at any age and is of equal frequency in both sexes.[3]

Islet cell tumors must be classified both on a pathologic and physiologic basis, not only to indicate the neoplastic but also the secretory characteristics. Most observers who have had experience with the tumors and have reviewed the literature, divide them into three groups for discussion: (1) benign islet cell tumor, (2) questionably malignant tumor and (3) carcinoma of the islet cell.[3] Each group either can be functioning or nonfunctioning. Warren[1,3] indicated that the pathologic criteria for islet cell adenoma are (1) arrangement and characteristics of the cells must be similar to those of normal island of Langerhans, (2) there must be a definite capsule and (3) there should be evidence of compression of the surrounding tissue.

The benign islet cell adenoma should meet these criteria. The questionably malignant tumor is that which shows microscopic evidence of malignant changes but no evidence of metastasis. In this group the prognosis is good and invasion of the capsule or surrounding blood vessels does not necessarily indicate that metastatic disease is or will be present.[3] Frank islet cell carcinoma not only shows microscopic evidence of malignant degeneration but metastatic disease as well and a diagnosis of carcinoma of islet cell should not be made without evidence of distant metastasis.[3] In this group the prognosis is extremely poor.[3] From experience, the questionably malignant islet cell adenoma rarely recurs or metastasizes. Anatomically, the tumor can be found most frequently in the tail of the pancreas but may occur in any location throughout the body and head or in ectopic pancreatic tissue.[3] The lesion may be single or multiple. Generally the tumor varies between 5 mm. and 15 cm. in diameter but the most common size found at operation is in the neighborhood of 2 cm.[1,3]

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Symptoms

If the tumor is nonfunctioning it usually is an incidental finding at laparotomy or autopsy.[2] Occasionally, however, a sizeable tumor may result in duodenal compression or obstruction, with the well known symptoms.[3] A nonfunctioning malignant islet cell tumor produces the same signs and symptoms as other cancers of the pancreas.[2] A functioning benign islet cell tumor gives rise to a group of rather characteristic symptoms, all of which are related to the overproduction of insulin with its attendant insulin shock. The recurrent episodes of insulin shock can be manifested in a great variety of symptoms, among which are loss of consciousness, feeling of weakness, delirium, convulsions, marked hunger, and various other psychic and emotional disturbances.[3] In a large majority of cases, the patient, at one time or another has been referred to a psychiatrist before the diagnosis was established.[3] Characteristically and understandably the episodes most frequently occur after long periods without food or after a period of excessive physical exertion. Most commonly the longest period without food is between the evening meal and breakfast. Thus, the effects of hyperinsulinism often manifest themselves before breakfast.

Most of these patients soon realize the timing of these attacks and will eat frequently or continually to try to prevent them.[3] They will fail to exercise because they are afraid of precipitating an episode.[3] Hence, a large majority are obese. Fortunately, most have intense hunger during an early stage of the attack and have learned the meaning of this.[3] They come prepared with a candy bar on their person, which further leads to the obesity problem. This, in turn, often renders finding of the adenoma more difficult at the time of surgery.[2,3]

Because the metabolism of the brain depends entirely on the maintenance of glucose as well as an oxygen supply in adequate amounts, prolonged or multiple attacks often lead to a variety of central nervous system and peripheral nerve changes.[1,3] There frequently are mental deterioration and personality changes. There also have been reported peripheral neuromuscular atrophy, disturbance of speech mechanism and epilepsy.[1,3] There is no definite relation between the blood sugar level and the clinical manifestation.[1,3] One patient may experience no loss of consciousness with blood sugar level in the neighborhood of 40 mg. per cent, another may be in profound shock with a level of 50 mg. per cent.[3] Most of them have learned to live with their disease merely by eating a candy bar or drinking a glass of orange juice.

Diagnosis

The diagnosis of functioning islet cell adenoma of the pancreas, of course, depends upon the overproduction of insulin.[3] The nonproductive tumor is diagnosed only as an incidental finding at laparotomy or at autopsy unless its size reaches a proportion such as to cause duodenal compression or obstruction.[3] Overproduction of the insulin is diagnosed specifically by the triad of findings established by Whipple in 1928 and now known as "Whipple's triad." The criteria for the triad are [1,3] (1) signs and symptoms of insulin shock frequently induced by fasting or exertion, (2) repeated fasting blood sugar concentration below 50 mg. per cent and (3) complete relief of symptoms by oral or intravenous administration of glucose.

At present, there is no convenient method of measuring the level of circulating insulin which can be used as a routine laboratory procedure.[3] We must rely on the secondary effects, on the serum levels of the glucose. Occasionally, even in the presence of Whipple's triad, a tumor will not be found either at laparotomy or autopsy. This circumstance, however, is rare and if the criteria of the triad are rigidly adhered to, a functioning islet cell tumor will be found on careful exploration of the pancreas in the great majority of cases. In more than half of the cases, the blood glucose level is lower than 50 mg. per cent. This, however, will respond to oral or intravenous administration of glucose.

Laboratory Tests in Hyperinsulinism Suspects

A number of laboratory tests have been used in the study of suspected hyperinsulinism patients. Only a few, however, have merit as aids in establishing the diagnosis. Blood sugar determination during an episode is the most important test in the diagnosis of these tumors.[1,3] In most cases a level below 50 mg. per cent during an acute episode will establish the diagnosis. The blood should be drawn early during an attack in order to obtain the lowest figures since the body defenses such as the adrenalin secretion may cause mobilization of the liver glycogen, with a compensatory rise in the blood sugar.[3]

The fasting glucose tolerance test usually will bring on an acute episode in a matter of twelve to thirty-six hours. Sometimes, however, it may have to be extended from 48 to 72 hours. This test correlated with the blood sugar levels should be given the greatest emphasis in the diagnosis of islet cell lesions. Water, tea and coffee without cream or sugar are allowed if desired and the patient is otherwise kept NPO.[3] As soon as there is the slightest indication of an attack, which the patient usually can feel, a blood sugar

level is determined and the patient observed carefully. In general there is no correlation between the histologic type of tumor and the ability to withstand starvation.[3] Occasionally, one will find a case in which hypoglycemic symptoms will not develop with prolonged fasting and if exercise is added to the withholding of food, the symptoms may then appear and blood sugar levels determined. This is referred to as the provocative exercise test.[3] The glucose tolerance test has no place in the diagnosis of this condition since various types of curves may be found and the correlation between the amount of insulin and the serum levels of glucose is not well established.[1,3]

Treatment

Nonfunctioning carcinomas of islet cells are treated like other cancers of the pancreas.[1,3] In functioning islet cell carcinoma the patient usually is operated upon with the preoperative diagnosis of benign islet cell tumor.[2] Its malignant nature is learned only by finding metastases at the time of operation. In such cases the treatment would depend upon the "resectability" of the primary tumor and the extensiveness of the metastases.[3] Any functioning islet cell tumor that is accompanied by no evidence of metastases should be removed regardless of how malignant it appears locally.[2,3] Nonfunctioning benign islet cell tumors are usually incidental findings at operation and are frequently removed by local excision chiefly because the surgeon is not sure of their true nature.

Functioning benign islet cell tumors should be removed by surgical operation as soon after the diagnosis has been established as can be arranged.[3] If the condition is allowed to remain untreated, the patient becomes obese due to the increased intake of carbohydrates which will increase the difficulty of operation.[2,3] The obese patient is a more formidable risk at surgery. Furthermore, mental deterioration occurs with the repeated episodes and may become irreversible.[1,2,3] An untreated patient may die in an episode of insulin shock.[1,2] The only treatment for islet cell adenoma is surgical removal.[3]

During exploration the pancreas should be completely mobilized so that it can be palpated both anteriorly and posteriorly between the fingers. Exploration of the pancreatic body and tail may be carried out through the gastrocolic omentum by raising the inferior border of the pancreas so that a hand may be passed behind. The pancreatic head, of course, is carefully explored by Kocherization of the duodenum and by palpation of this structure between the thumb and forefinger.

Prior to exploration of the pancreas itself, the entire abdominal cavity should be carefully inspected for evidence of ectopic pancreatic tissue which may contain a functioning adenoma.[3] If the tumor is located by palpation or visualization, or both, it may be enucleated with a small amount of surrounding normal pancreatic tissue.[1,3] The results are very satisfactory. This method can be utilized if the tumor is not large and if it is not located adjacent to one of the major pancreatic ducts which might be injured in the removal.[3] It usually is safer and easier, however, when the adenoma is located in the tail to resect the entire distal end of the gland and, in fact, some tumors in the head of the gland may require total pancreatectomy.[1,3] When no adenoma is found after a thorough search, distal pancreatectomy, in which the entire tail, body and neck of the gland are removed, is carried out.[1,2,3] This is predicated on experience as approximately 75 per cent of the adenomas will be found in this region.[3] Total pancreatectomy sometimes is necessary but should be reserved until after every conceivable means of finding other intrapancreatic or aberrant pancreatic adenomas has been carried out.[3] Postoperative consequences of total removal of the pancreas are so profound that the procedure should not be regarded lightly.[1] Furthermore, distal pancreatectomy should be performed and the tissue examined before concluding that total pancreatectomy is justifiable.[3] In approximately 12 to 14 per cent of cases multiple adenomas may be present and the finding of a single tumor should not stop the diligent search for others.[2]

Case Report

A 54-year-old white female school teacher presented herself as in good health until 1958. At that time she "passed out in front of her class" for no apparent reason. The principal was summoned and, for lack of something better to do, gave her a glass of orange juice. Fifteen to twenty minutes later she was well and remained normal until the following year when she again "passed out" in the school cafeteria. Again orange juice was administered and she responded. She saw her local family doctor who advised hospitalization and admitted her for a complete work-up. During this admission, blood sugars were drawn which showed levels of 35 to 38 mg. per cent. There also were normal levels. Apparently the true diagnosis was not suspected and she was referred to a psychiatrist because of some confusion and giddiness. During that hospitalization she was given a high caloric diet of 5,000 calories per day and had no further attacks.

In January of 1962 she had similar attacks and was readmitted to the hospital by another physician. Approximately the same type of work-up was performed with the same findings. Again the nature of the disease was not suspected and she was discharged with instructions to follow a high caloric diet with frequent feedings. In January of 1963 she had the same symptoms of shock, weakness, numbness and confusion. Again she was rechecked, with the possibility of pancreatic disease. At that time she was also examined for a possible brain tumor. Skull X-rays, neurological consultation and an electroencephalogram were carried out but no definite diagnosis was established. Shortly afterwards she was readmitted to the hospital emergency room at which time a blood sugar of 15 mg. per cent was reported. She was given a glass of orange juice, responded promptly, and was released. For the next two months before her final admission, the patient found that she did not awaken in the mornings. Her daughter, who lives with her, discovered that by pouring approximately two tablespoons of Karo syrup down her throat, she would respond in fifteen or twenty minutes. The patient states that during that period she learned that if she drank a large glass of milk before retiring and then arose early in the morning and had breakfast immediately, she could avert the symptoms. She states also, however, that many mornings she awoke to find herself and her hair filled with sticky syrup. Throughout the day if she attempted to do anything unusual such as mowing the lawn, she began to feel weak and numb and had to rush into the house for a drink of Karo syrup and rest ten to fifteen minutes before she could go back and finish the job.

This patient was first seen in our office in August, 1963. Her chief complaints at that time were unrelated to her pancreatic adenoma and hospitalization was advised for surgical correction of the other condition. At that time she stated that since she was to have a general anesthetic, she thought it would be wise if we knew the past history which she related as follows:

1. "I cannot wake up in the morning and I black out when I exercise."
2. "The only thing that will wake me up when I pass out or do not wake up is Karo syrup if someone pours it in my mouth."
3. "One time I was admitted to the emergency room of the hospital and my blood sugar was 15."

This suggested Whipple's triad immediately and she was advised of the possibility of islet cell adenoma. A work-up was advised and she readily agreed because she was quite disturbed by waking up in the morning with her hair sticky with syrup.

She was admitted to the hospital and the other minor operative procedure was carried out without incident. She was then put on a low caloric diet of 50 Gm. of protein, 50 Gm. of carbohydrates and 1,200 calories per day. Daily fasting blood sugars were ordered. The first was reported as 50 mg. per cent. Thereafter, consecutive b. i. d. blood sugars were 45, 53, 47, 51 and 45. In the afternoon of the third postoperative day, with the patient on the above mentioned low caloric diet, she had sudden loss of consciousness, with coma. Blood was drawn and the glucose level was reported 12 to 15 mg. per cent. She was immediately given 35 cc. of 50 per cent glucose intravenously and within ten minutes apparently was normal. She continued on the low caloric diet of 1,200 calories for the next three days and in the afternoon of each day had loss of consciousness; on each occasion blood sugar levels of 10 to 12 mg. per cent were recorded and she responded immediately to intravenous glucose.

We felt that the diagnosis was established and the patient was returned to a regular diet with supplemental glucose feedings. No further attacks occurred. We then advised exploratory laparotomy and this was undertaken on the tenth hospital day. At surgery, careful search of the entire abdominal cavity failed to reveal evidence of any aberrant pancreatic tissue. The pancreas was mobilized as described above and on inspection one small area in the uncinate process was thought to be slightly firmer than the normal pancreatic tissue. A specimen was removed for biopsy purposes. Frozen section showed this to be normal pancreas. Since no definite adenoma could be found, subtotal pancreatectomy with removal of tail, body and neck was done. During the procedure the "lily was gilded" somewhat by preserving the splenic vein and artery throughout.

Upon removal of the body and tail, the specimen was sent immediately to the laboratory where serial sections revealed a 1.5 cm. firm, pinkish, isolated tumor in the tail portion of the gland embedded well within the substance of the tissue. Subsequently, microscopic examination showed this to be a benign adenoma. Following the operative procedure the patient was given intravenous glucose and her blood sugar levels were carefully recorded. On the first postoperative day, the fasting blood sugar level was 124 mg. per cent. On the second postoperative day it was 247 mg. per cent and she was placed on a sliding scale with regular insulin. Eventually

she was placed on 30 units of NPH insulin daily and started on tolbutamide tablets QID, PC, and HS. The patient was at that time on a regular diet and tolerated the medications well, with the blood sugars running in the neighborhood of 120 mg. per cent by the seventh postoperative day. The NPH insulin was discontinued and she was maintained on the tolbutamide orally. The fasting blood sugar level rose approximately to 160 mg. per cent but came down on the following days to range between 100 and 118 mg. per cent, at which level it was at the time of her discharge on the tenth postoperative day.

The tolbutamide probably was not necessary at that time but it was felt to be a safety precaution since it is known that this drug will not lower the serum glucose below normal levels. During the next four weeks the tolbutamide was gradually withdrawn and the patient has maintained a normal glucose level ever since. She has no further symptoms and, in fact, has been on a self-imposed dietary restriction to lose weight. She has lost approximately 30 pounds and has had no difficulty whatever. Postoperatively she had a draining fistulous tract for approximately five weeks which gradually subsided and healed spontaneously.

Conclusions

The functioning islet cell adenoma of the pancreas is a relatively rare entity but the diagnosis often is overlooked because it simply is not suspected. The diagnosis can be established by demonstrating Whipple's triad. Once this is accomplished, surgical exploration and removal are mandatory for cure. The surgical exploration must be thorough to exclude aberrant locations of the tumor and the exposure must be extremely generous.

We have reported a case which we feel is classic in that the Whipple's triad was distinctly demonstrated and it also shows the course these patients usually follow in the hands of the unexpecting clinician. With the diagnosis established and the tumor removed, results have been most gratifying.

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Fatal 'Blood Poisoning'—Remember?

The pharmaceutical concerns, who with the doctors have given so many lifesaving truly wonder drugs to the people, also have never been maligned so much. Why? Because of our combined efforts some of the greatest killers exist no longer. Many of my colleagues and I remember only too well how several decades ago we stood helplessly by as we watched people die of meningitis, typhoid fever, influenza, polio, tuberculosis, diphtheria, and streptococcus and many other infections. Hundreds of thousands of children died or were maimed with blindness, deafness and paralysis from such ailments as diphtheria, scarlet fever and polio. Pneumonia was a great killer.

In recent years, we do not hear any more of anyone dying of a ruptured appendix. It is now most unusual, although very frequent before. Infections were untamed without sulfas and antibiotics. A simple scratch could cause blood poisoning and death. President Coolidge lost a teenage son as the result of an infection of a little blister on his foot.—William L. Gould, M. D., in New York State General Practice News.

Hypoglycemia Following Sulfonylurea Therapy

A. B. Curry Ellison, M. D., William C. Stewart, M. D., and Alfred K. Pfister, M. D.

The sulfonylurea compounds have achieved widespread popularity in less than a decade and have proved their efficacy in the treatment of noninsulin-dependent diabetes mellitus. The two compounds in this group which are used most extensively in this country are tolbutamide and chlorpropamide.

It has been established that the sulfonylurea compounds stimulate the pancreatic beta cells and thus cause degranulation, with a concomitant increase in insulin demonstrable in the pancreatic venous blood (Figure 1).[1] The increase in insulin causes not only a decrease in the hepatic glucose output but also an uptake of glucose by the liver.[2] Experiments using rat livers have established the fact that the sulfonylurea hypoglycemic agents specifically lower the hepatic glucose output.[3] Knowledge that plasma insulin exists in an active free or unbound form and as an inactive bound complex has been used by other investigators[4,5] who have reported that large amounts of biologically inactive insulin complexes were demonstrable after infusion of intravenous glucose in selected cases of noninsulin-dependent diabetics. Following a rise in blood glucose in the normal individual, there is a rise in the free active insulin in the plasma whereas in some diabetics insulin continues to circulate in the inactive bound form, representing either excess binding of insulin or inability to dissociate from these complexes to the active unbound form. They were able to show that tolbutamide would increase the rate of utilization of the bound insulin complexes in the blood. Finally, some workers[6] have shown that the sulfonylurea drugs may exhibit an effect on the peripheral uptake of glucose similar to the effect of insulin.

Certain hazards are inherent in the use of these agents. Side effects that are becoming more widely recognized are skin rash, gastrointestinal symptoms, hematological disorders, hepatic toxicity and hypoglycemia. Two cases of hypoglycemic reaction following sulfonylurea drugs have been selected from our records to illustrate some unique features of the condition.

Case 1—An 80-year-old white female with known arteriosclerotic heart disease of nine years' duration was admitted to Charleston Memorial Hospital, having reportedly become suddenly unconscious three hours previously. She was known to have had diabetes for the past five years for which she had been treated by dietary restriction and chlorpropamide 250 mg. daily. Five days prior to admission sore throat and malaise had developed. During the subsequent days increasing glycosuria was noted. She consulted her local physician one day prior to admission and was advised to increase the chlorpropamide to 750 mg. daily. She also had been receiving digitoxin 0.1 mg. daily, and diuretics intermittently for the past nine years.

Physical examination revealed an elderly white female unresponsive to stimulation. Blood pressure was 125/105, pulse 112 and irregular and respirations were 16 per minute, with periods of shallow breathing. The skin was warm and dry, with some diminution in turgor. Pupillary dilation was not observed. The neck was extremely flaccid. Examination of the heart revealed tachycardia of 112 with frequent extrasystoles. No abdominal distention was noted. Deep tendon reflexes were greatly depressed. Extreme flaccidity was noted in all extremities. No other neurological abnormalities could be demonstrated.

The initial impression favored cerebrovascular accident but shortly thereafter a blood sugar determination of 26 mg. per cent was reported.* Intravenous glucose administration corrected the state of unresponsiveness.

Comment

The physical findings in this case were occult for the diagnosis of hypoglycemia. When hypoglycemia occurs rapidly a compensatory rise in

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***Smogyi-Nelson technique.**

blood epinephrine levels will produce rather characteristic signs and symptoms; should the fall in blood sugar be a more gradual process, however, confusion and disorientation followed by unresponsiveness, as in this case, may be the only manifestations. Transient neurological abnormalities suggesting a cerebrovascular accident may be detectable during these episodes but disappear after correction of the hypoglycemic state. It has been suggested that these are caused by a metabolic insult to areas already susceptible because of a marginal blood supply.[7] Thus it appears that a confusing clinical picture may be presented when there is a gradual fall in blood sugar to hypoglycemic levels in elderly diabetic individuals with an already increased susceptibility to arteriosclerosis.

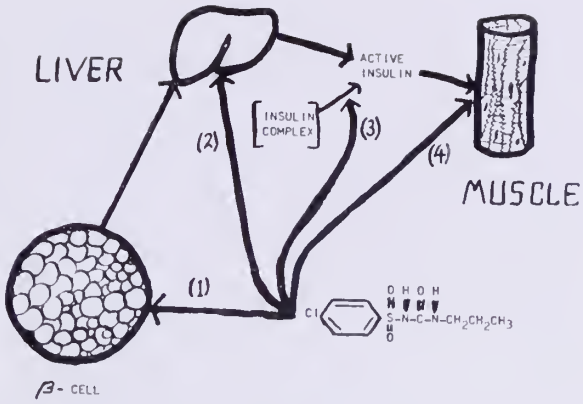

FIGURE 1. The sulfonylurea drugs produce their hypoglycemic effect by (1) stimulating insulin release from the beta cells which increases hepatic glucose uptake and decreases hepatic glucose production, (2) acting directly on the liver to decrease hepatic glucose output, (3) increasing the rate of utilization of inactive insulin complexes in the blood and (4) facilitating peripheral uptake of glucose.

Chlorpropamide vs. Tolbutamide

Chlorpropamide is rapidly absorbed from the gastrointestinal tract but its recovery from the urine is slow, the plasma half-life being close to 35 hours.[1,8] An advantage of the drug over tolbutamide is that on many occasions a single daily dose suffices.[9] Some investigators have reported greater effectiveness for chlorpropamide;[1,10] this may be a result of its longer duration of action. Others, however, have felt that it does not increase the spectrum of patients who will respond to the sulfonylurea drugs.[9] Its prolonged half-life necessitates alertness for protracted or recurring hypoglycemia over a period of several hours after the initial episode.

Case 2.—A 71-year-old white female with known diabetes four months prior to her last admission was treated initially by dietary control. This failed to correct the hyperglycemia over a two-month period and necessitated institution of tolbutamide therapy 1.5 Gm. daily. Seventeen days later she was seen in the emergency room, reportedly having had an episode of confusion, difficulty in seeing, cold sweats and loss of consciousness two hours previously. She responded at that time to intravenous glucose quite dramatically within a few minutes. Blood sugar was reported as 60 mg. per cent.* Additional history revealed that the patient had had chills, fever, dysuria and difficulty in voiding over the past week. A residual volume of 1,200 ml. of urine was noted. Dietary appropriations and tolbutamide 1.0 Gm. daily during the next five days in the hospital established satisfactory diabetic control. Blood urea nitrogen, 47 mg. per cent on admission, fell to 26 mg. per cent on catheter drainage and urethral dilatation. Appropriate antibiotic therapy was instituted for bacilluria. The patient was discharged to follow-up on tolbutamide 1.0 Gm. daily and dietary control.

Twenty days after discharge, the patient again was seen in the emergency room, her family having found her unresponsive two hours previously. Blood pressure was 100/70, pulse 120 and regular, respirations 20 per minute and shallow, and temperature 101.4 F. (rectally). The skin was warm and dry. There was poor orientation to time and place but response to painful sensations. Pupils were fixed in moderate dilation, with mature cataracts bilaterally. There was a well-healed radical mastectomy scar on the left. A few scattered, moderately coarse, inspiratory rales were heard over the lung bases posteriorly. Examination of the heart other than a regular tachycardia of 120 was unremarkable. The liver was palpable 3 cm. below the right costal margin; its edge was smooth and nontender. Neurological examination revealed symmetrical depression of the reflexes in the lower extremities. Babinski's sign was present on the left. No other abnormalities were noted.

Upon the infusion of intravenous glucose the patient became responsive and was able to give a reliable history. For the past week she had experienced postprandial discomfort in the epigastric area, associated with nausea and vomiting on occasion.

The next morning (19 hours after admission) the patient again appeared to be poorly oriented and confused. Blood sugar was 49 mg. per cent.* Intravenous glucose again corrected this abnormal state. When an indwelling catheter was inserted a large residual volume of urine was noted.

*Smogyi-Nelson technique.

Laboratory.--Hematocrit 25 vol. per cent, hemoglobin 9.9 Gm. per cent, WBC 35,000 cells per cubic mm. Differential count: 89 per cent segmented neutrophils, 5 per cent band neutrophils and 6 per cent lymphocytes. Platelet count: 140,000 cells per cubic mm.** Reticulocyte count and red cell indices were normal. Bone marrow aspiration showed generalized hyperplasia of the granulocytes. Repeat white blood counts remained persistently elevated in a range of 25,000 to 30,000 cells. Urinalysis showed specific gravity of 1.005, alkaline P_H., albumin 30 mg., 4 plus WBC per HPF and a rare white cell cast. Serum lipase and amylase were within normal limits. Liver function tests showed BSP retention of 36 per cent, total protein 5.5 Gm. per cent, with 2.3 Gm. per cent albumin and 3.2 Gm. per cent globulin, total bilirubin 1.2 mg. per cent with 0.47 mg. per cent direct reacting, alkaline phosphatase 7.0 SJR units† and cephalin flocculation of 2 plus at 48 hours. Fluoroscopy of the upper intestinal tract was normal. Cholecystograms revealed multiple cholesterol stones. A cystometrogram revealed a hypotonic bladder apparently due to diabetic neuropathy.

The admission BUN of 93 mg. per cent fell gradually to 26 mg. per cent with catheter drainage. The tolbutamide dose was subsequently regulated at 0.5 Gm. daily, with dietary measures.

Comment

The above case illustrates that even though tolbutamide has a half-life limited to a matter of hours,[1] in certain circumstances it may be the cause of rather prolonged hypoglycemia. Admittedly, this is an uncommon manifestation.[8] The patient's hepatic and renal disease coupled with a poor caloric intake may have been responsible for the recurring hypoglycemic episode.

In the body, tolbutamide is bound almost entirely to the albumin fraction of plasma proteins.[12] It is metabolized by decarboxylation in the liver.[1] It has a known half-life of four to five hours[1,8,11] and is excreted largely in the urine. Delay in hepatic decarboxylation and failure of renal excretion have been suggested as being the possible mechanisms for prolonged tolbutamide hypoglycemia.[8]

Recently it has been shown that cirrhotic subjects have a delayed disappearance of plasma tolbutamide levels as compared to noncirrhotic diabetics.[13] Furthermore, prolongation of hypoglycemia was observed in some of the cirrhotic subjects with prolonged plasma tolbutamide levels. This indicated that the delayed hepatic tolbutamide metabolism may be a factor in promoting protracted tolbutamide hypoglycemia. In other cirrhotics with a prolonged plasma tolbutamide half-life these changes did not occur. This suggests that impaired glucose uptake and release of glucose by the liver also may be factors in maintaining hypoglycemia. We feel that the liver disease in Case 2 probably represents a nutritional metamorphosis; we were unable to confirm the cholelithiasis as a definite factor without laparotomy or biopsy.

It also has been proposed among other factors that failure of renal excretion of tolbutamide may be a possible cause of prolonged hypoglycemia. It has been shown that the disappearance rate of plasma tolbutamide is reduced in those patients with impaired renal function and that there was good correlation of the tolbutamide half-life with the GFR and NPN.[13] These patients, however, did not illustrate any prolonged duration of hypoglycemic response compared with normal subjects.

Other factors have been mentioned that could be responsible for prolonged tolbutamide hypoglycemia. It has been shown that sulfonylurea-sensitive diabetics show a much greater hypoglycemic response when challenged with a standard dose of the amino acid *L*-leucine and 0.5 Gm. of chlorpropamide than insulin-dependent diabetics and pancreatectomized subjects.[14] This is to be expected since it is thought that *L*-leucine stimulates the beta cells to release functionally active insulin. Potentiation of a sulfonylurea with an adequate amount of *L*-leucine in the regular diet could occur if it were ingested all in one meal rather than being divided into three portions a day.[8]

An impaired compensatory glucose release also may be a responsible factor in prolonged hypoglycemia of this nature. Patients with severe liver disease and depleted glycogen stores may exhibit a poor response to hypoglycemic stimuli. If tolbutamide levels remain elevated for some time, continued draining of hepatic glycogen stores could be sufficient to account for prolonged hypoglycemia.

Before considering the use of these agents, clinical and laboratory evaluation of liver and kidney function should be determined since functional abnormalities of these organs are not uncommon in the diabetic subject. In a great many elderly diabetic patients concomitant diseases may result in daily fluctuations of caloric intake due to anorexia, nausea and vomiting. These may further alter the metabolic balance in an already marginal situation.

**Brecher-Cronkite phase (140,000 to 400,000 normal)
†Normal SJR units 2.2 to 8.8 for adults.

Summary

The mechanism of action of the sulfonylurea drugs is discussed, with emphasis on current concepts. Two cases of sulfonylurea-induced hypoglycemia are reported. One case emphasizes atypical findings in hypoglycemia; the other illustrates prolonged hypoglycemia due to a short-acting sulfonylurea agent. The mechanisms of action of prolonged tolbutamide hypoglycemia are reviewed. Stress is placed on the necessity for adequate hepatic and renal evaluation before use of the sulfonylurea agents.

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Implications from Abroad

NEWSPAPERS continue to report tragic instances wherein physicians have withdrawn from all except emergency service to the public. These activities have caused headlines in Italy, Japan, Saskatchewan, and more lately Belgium. In each situation the physicians of these nations have objected to proposed or actual government interference in medical practice by legislative fiat. In no instance has the curtailment of service been a "strike" against the patients themselves.

Whatever your opinion on such action on the part of physicians may be, you must measure the morality of any nation that is willing to legislate against any free profession in a discriminatory way. Government regulation can destroy free enterprise medicine in the United States as it has in other countries. We must analyze and identify the factors which may apply to us. The curtailment of services was only a culmination of frustrating complacency of the medical profession and a misunderstanding of the public. Neither legislators nor voters spontaneously ask advice before fashioning laws which concern health care.

Unfortunately American physicians are both busy and naive. As individuals, we are not sufficiently alive to the political shenanigans which will ultimately control the practice of medicine. The biggest threat to the physician's own security is his disinterest in what has gone on abroad. We, in this country, must develop more vigilant, aggressive leadership which will seize the initiative, develop policies, and offer practical solutions to problems in this decade of social change. We need to concern ourselves more deeply with the politics and economics of medical care. We can no longer afford the luxury of standing by as disinterested onlookers. Implications from abroad for the future have never been clearer.—Donald N. Sweeney, M. D., in Detroit Medical News.

Report of the School of Medicine West Virginia University

(July 1, 1963 through June 30, 1964)

Clark K. Sleeth, M. D., Dean

At West Virginia University the Dean of each School or College submits an Annual Report to the President of the University. These reports consider the objectives of the School together with progress toward these objectives and problems encountered during the year.

Because we are convinced that the physicians of the State have a continuing interest in the progress of the University School of Medicine we have submitted the following material from the most recent report for publication in *The West Virginia Medical Journal.*

The Author.

- **Clark K. Sleeth, M. D., Dean, West Virginia University School of Medicine, Morgantown, W. Va.**

I. AIMS AND OBJECTIVES

The single, continuing, general aim of the School of Medicine is the advancement of the health of the individual in the community in which he lives. Progress toward this aim may be accomplished through a series of educational, research and service objectives.

Educational Objectives

1. Preparation of undergraduate medical students for any of a variety of careers leading to general practice, specialty practice, research and teaching or various combinations of these.

2. Participation in organized intramural and extramural programs of education for practitioners of the healing arts to the optimal extent consistent with available resources.

3. Encouragement and assistance in provision of programs of education in the many essential paramedical services.

4. Provision of specific programs for:
   a. Introduction to human biology.
   b. Systematic development of self-education.
   c. Application of principles of human biology to patient care and public service.
   d. Advanced study in basic and clinical sciences.

5. Recognition of the variety and diversity of educational needs. Students vary more than is commonly recognized in individual capacities, and in educational expectations.

Research Objectives

A primary responsibility of the School is the extension of knowledge in all areas of human biology.

Service Objectives

1. Intramural—Provide highest quality patient care in the University Hospital and Clinics for the number and variety of patients needed to serve the educational objectives, avoiding expansion of patient services for their own sake.

2. Extramural—Cooperate through the University's Appalachian Center for Research and Development and through the many other appropriate agencies, in educational and demonstration projects calculated to improve standards of health and health care in communities, to the extent made possible by available resources.

II. PROGRESS AND PROBLEMS DURING 1963-64

Administration

1. A special committee of faculty to initiate a program of long-range planning for the School was active during most of the year and submitted a formal report on May 10, 1964. This report has been forwarded to appropriate administrative officers of the University and can help serve as a basis for a coordinated planning effort for the Medical Center as a unit.

2. The duties of the sole Assistant Dean were defined more clearly, and now comprise primary responsibility for all areas of student affairs including recruitment, selection, counseling and evaluation of progress, and for curriculum review, revision and development.

3. Collection from eligible patients of fees for professional services rendered by members

Submitted to the Publication Committee, October 20, 1964.

of the faculty has been a service function of the office of the Dean. A contractual arrangement with the Hospital Business Office has resulted in a significant increase in efficiency and effectiveness of this operation.

4. Reorganization of the Department of Anatomy has progressed to the point at which an offer of appointment to chairmanship has been extended to an excellent prospect, one of a number considered for this important post. There has been administrative commitment to the support of a number of faculty positions adequate to bring the strength of this department to a position comparable to the other departments of basic science.

5. A faculty search committee, including a representative of the School of Dentistry, has been appointed to seek and recommend to the administration the best available person for the chairmanship of the Department of Physiology. The present chairman of that department has agreed to continue until a replacement can be appointed.

6. The salary scales now in effect need considerable upward revision if we are to become competitive with other schools of medicine for talent. Progress in this respect during the year was disappointing.

7. There is clearly evident need for early review of space utilization throughout the entire Medical Center. Some active and productive departments are in urgent need of additional space. Some, but not all, of the immediate needs could be met by reassignment of space not now used at optimal capacity.

Educational Programs—Regular Curricula

A. Candidates for the M.D. degree.

1. Forty candidates have received the degree of M.D. since the last annual report. This brings the total number of M.D. degrees granted by the institution to 99 in a three year period. Future graduating classes will number 55 to 60 members each.

2. There is continuing study of the curriculum with emphasis currently concentrated upon more effective utilization of the time of the third and fourth years.

3. There has been perceptible improvement in the performance of our students in the standard examinations of the National Board of Medical Examiners. We believe that further progress in this respect can be expected.

B. Candidates for M.S. and Ph.D. degrees. Six basic science departments offer programs leading to the above degrees, approved by the Graduate School of the University.

The following table summarizes these programs and indicates their growth over the past four years:

SCHOOL YEARS	M. S.		Ph.D.	
	Candidates Enrolled	Degrees Granted	Candidates Enrolled	Degrees Granted
Totals 1963-64	42	12	25	6
Totals 1962-63	43	9	16	3
Totals 1961-62	31	9	10	2
Totals 1960-61	16	9	5	0

C. Candidates for the degree of B.S. in Medical Technology. Eleven such degrees were granted at the June 1964 Commencement. Nineteen students completed the third year of the four-year curriculum and seventeen have been admitted to begin the work of the third year in September 1964. It is anticipated that further increased enrollment in this program should be evident in 1965. We propose an entering class of approximately 30 students as feasible in present facilities and with only moderate increase in faculty personnel.

D. Candidates for degrees in other schools and colleges. The faculty of the School of Medicine taught a total of 968 students in a total of 23 courses designed for students from other schools and colleges of the University. It should be noted that this large number excludes graduate students, who are accounted for elsewhere. We have agreed upon a policy of offering whenever possible one departmental course for students at the baccalaureate level and another for students at the doctoral (professional or graduate) level. Problems of integrating time schedules with other schools have to date prevented maximum utilization of this important means of increasing faculty efficiency, particularly for bachelor's candidates with courses outside the Medical Center.

Co-curricular Educational Programs

A. Bi-monthly lectures sponsored by the Medical Center continue to make available a variety of outstanding speakers.

B. Several departments have provided visiting professorships of a few days to a week or more in duration (in one instance a few months). The opportunity for students to observe the work of teachers from other institutions and to participate with them in daily routines is believed especially valuable.

C. The newly organized Division of Health and Preventive Medicine sponsored a series of six evening lectures, open to the public, dealing with the role of preventive medicine in community health.

D. The program of Medical Education for National Defense, sponsored and financed by the Armed Forces of the United States, continued active throughout the year.

E. The West Virginia Chapter of the American Academy of General Practice has organized to offer a program of preceptorships to be available to those students in the third or fourth year of Medical School who wish to spend three weeks of a vacation period working directly under the supervision of an individual general practitioner and living in his home. It is anticipated that this program should provide interested students an opportunity to become acquainted with this important and urgently needed type of medical practice.

Non-curricular Educational Programs

A. A total of 11 interns completed a year of training in the University Hospital under the supervision of the clinical faculty of the School of Medicine. Fourteen interns have been appointed for 1964-65. Initial steps to secure approval of straight internship in Pathology have been taken.

B. Residency training was provided during the year for 39 individuals distributed among departments as follows: Medicine, 10; Surgery, 20; Pediatrics, 2; Obstetrics and Gynecology, 2; Radiology, 2; and Pathology, 3.

C. Organized post-graduate courses for practicing physicians were conducted in the subject areas of pulmonary and cardiovascular diseases. In addition every clinical department and most major clinical divisions have sponsored at least one intramural session of one to two days for members of their respective specialty societies of the state or area. Regular weekly departmental and divisional clinical conferences are open to all practicing physicians. Their attendance and participation is encouraged.

D. In response to specific requests, faculty members have presented more than fifty educational programs at meetings of county or regional medical societies, hospital staffs or similar professional groups in the state and region.

E. At the annual meeting of the West Virginia State Medical Association in August, 1963, eight members of the faculty participated in a half-day program on Neoplastic Disease in the Chest. This program attracted good attendance and favorable comment. Similar participation in the 1964 program is assured.

Professional Staff

1. The following table summarizes the faculty as of June 30, 1964:

RANK AND TITLE	FULL TIME Filled	FULL TIME Budgeted But Unfilled	PART TIME OR CLINICAL	TOTAL FILLED POSITIONS
Professor & Chairman	12	1	0	12
Professor	7	0	8	15
Associate Professor	23	2	10	33
Assistant Professor	30	5	20	50
Instructor	15	13	20	35
Totals	87	21	58	145

(Author's subsequent note: Of the 21 positions budgeted but unfilled on June 30, 1964, 14 were filled by October 1, 1964).

2. The chairmanship of the Department of Psychiatry, vacated on September 25, 1963, by the resignation of Thomas A. Loftus, M.D., was filled on January 1, 1964, by the appointment of Robert L. Vosburg, M.D.

3. The Division of Neurology of the Department of Medicine has been strengthened by the appointment on June 1, 1964 of Hartwell G. Thompson, M.D., as Professor of Neurology and Chief of the Division. Provision for two additional neurologists has been assured, and one instructor has been secured for appointment on July 1, 1964.

4. Progress with regard to the reorganization and expansion of the staff of the Department of Anatomy has been indicated in Section II, 4, of this report.

5. Decision to seek a new chairman for the Department of Physiology was reached in June, 1964, by the administrative officers of the Medical Center, and a faculty search committee is at work.

6. Action at Medical Center level creating a post of Director of Medical Communications was followed by the appointment of James E. Dyson, Jr., Ph.D., to the position. We anticipate considerable facilitation of organization of post-graduate offerings as well as improvement in such internal services as photography and illustration as a result of this action. Decision to employ a qualified veterinarian as Director of Animal Facilities should also result in improvement in the operation of that important facility.

7. We need to remain aware of the need for additional faculty in virtually every department, and of the need to improve salary scales if we are to retain present faculty and attract new. One outstanding associate professor rejected an offer involving a salary increase of $2,000 at another institution and saw a new Ph.D., of only average ability, whose work he had supervised, accept another position at a starting salary in excess of what he himself is now paid. Another associate professor has resigned to accept an-

other position at an increase in salary of $2,400 per year.

Facilities

1. A number of facilities have been added or improved during the year.

a. A new central, non-departmental, laboratory for animal research in cardiovascular phenomena is fully operational.

b. Laboratory facilities in the Department of Pathology for teaching clinical laboratory techniques to medical students and medical technology students have been expanded and improved.

c. Increased office space for the expanding Department of Pediatrics has been created and the Hospital facilities for this department were expanded by some 50 per cent.

d. Provision of a Medical Center electronics maintenance shop has helped considerably in keeping much important sensitive and expensive equipment operational with minimal delays.

2. There are many further needs for alteration or addition of facilities to meet expanding and changing requirements of programs of the School. These are dealt with in more detail in the report of the Long-Range Planning Committee of the School and will only be enumerated here.

a. Additional office and research laboratory space.

b. Modification of some teaching laboratory and lecture rooms.

c. Expansion and improvement of animal quarters.

d. Modernization and improvement of radiology facilities, especially for radiation therapy.

e. Expansion of Hospital bed capacity without jeopardizing teaching budgets.

f. Provision of house staff quarters, improved access roads, et al. At present federal funds on a generous matching basis are available for many of these purposes and we should plan to take maximum advantage of this opportunity.

Medical Students

1. Students enrolled in the medical curriculum are enumerated in the following table:

Year	Enrolled	Regularly Promoted	Irregular Progress	Dismissed or Withdrew
First	60	52	6	2
Second	58	57	1	0
Third	60	60	0	0
Fourth	41	40	1	0
TOTALS	219	209	8	2

2. Sixty-one students have been selected to enroll as freshmen in September 1964. The following table summarizes the size and nature of the pool of applicants from which the class was selected.

	Applications Requested	Application Forms Supplied	Completed Applications Received	Acceptances Issued	Students Accepting Places
W. Va. Residents	165	165	141	64	52
Non-Residents	1126	188	139	14	9
TOTALS	1291	353	280	78	61

We are encouraged by the continued apparent improvement in the qualifications of the students chosen for admission. Nationally the number of applicants to medical schools is again increasing. There will continue, however, to be sharp competition among schools of medicine for the best qualified students and we must improve our recruiting efforts in this direction, including our ability to offer scholarship support.

Research and Publications

1. It is the policy of the School to encourage research by every faculty member. Recognizing individual variability in interests no set rule applies to proportionate distribution of individual time, but at department level in the Basic Sciences we plan to staff so as to make possible approximately equal division of time between teaching and research. In clinical departments the policy is approximately even division among teaching, patient care, and research.

2. During the year a total of 111 separate grants or contracts in support of sponsored research were in effect. The total monetary value of these awards was $1,294,345. Our ability to recruit and retain faculty members is enhanced greatly by the availability of these funds, chiefly from federal sources, for the support of research. Only a very limited proportion of these funds can be used, however, for the direct salary support of faculty members. A total of 139 scientific papers were published from the School of Medicine in the year 1963-64.

3. Faculty members report 232 individual attendances at national meetings of scientific groups. A total of 66 papers were presented at national meetings. One associate professor presented a paper at an international scientific assembly.

Service to Patients

(Author's Note: The information in this section is taken from the Annual Report of Mr. E. L. Staples, Director of the University Hospital. We wish to express our thanks to him for permission to include this material.)

West Virginia University Hospital has become in reality a referral center for patients from

throughout the State. Review of the most recent one thousand consecutive admissions revealed patients referred from 42 of the 55 counties. More than 39,000 individual patients have been registered since the Hospital opened in August 1960. Eighty-five to 90 per cent of these are West Virginians. When facilities are available we will admit patients from other states providing they are properly referred and have resources to pay for their care.

During the past year there were 7,478 admissions to the Hospital and 88,473 patient-days of care were provided. Out-patient visits totaled 48,905. Average daily census is 85 per cent or more of available beds. During June 1964, fifteen new beds were opened as an addition to the Pediatric Service, bringing total available beds to 320. Sixty-five additional adult beds will be opened this fall. (This has been accomplished during October 1964, before publication of this article.) Bed capacity has kept pace with teaching needs as class size has increased in the School of Medicine.

A short, handwritten discharge summary for transmittal to the referring physician immediately upon patient discharge was instituted during the year. This summary, followed later by a more detailed account of the Hospital course of the patient, has improved our communications with the referring physicians.

By maintenance of high standards of patient care and good communication with the medical community of the State we hope to continue to receive the fine cooperative support from physicians which we have enjoyed to date.

Amphetamines and The Turnpike

MISUSE of amphetamines by truck drivers is a hazard created by a minority to extend their fatigue limit. The industry does all it can to circumvent this practice. Many drivers to not fully recognize the potential dangers of amphetamine misuse. The unsuspecting truck driver may be continuously exposed to the drug because of widespread misuse by other truck drivers and through the efforts of illegal peddlers of the drug who are anxious to sell at enormous profit.

The drug, when used to extend the normal driving range, obscures nature's danger signals of fatigue. The driver may thus force himself to stay awake to the point of physical exhaustion. At this point the artificial occupation hazard becomes a potent highway hazard. Many fatal road accidents have been caused by the illegal use of amphetamines. The trucking industry has cooperated extensively with the Federal Drug Administration in efforts to break up the practice.

An illustration of what these drugs can do is an accident that took place on the West Virginia Turnpike early this year. A flat-bed tractor trailer and a highway post office van collided head on with such force that both drivers and three postal clerks sorting mail in the back of the post office van were killed instantly. Investigation showed that the flat-bed truck was traveling on the wrong side of the road at the point of impact. The road was free of ice, and visibility was good. Investigators searching the wreckage found amphetamine capsules in a matchbox in the shirt pocket of the trailer truck driver. Analysis of the driver's stomach contents revealed the presence of amphetamine. It seemed evident that the truck driver was under the influence of this drug at the time of the accident. The four postal employes were innocent victims.

The illegal distribution of this type of drug has reached multimillion-dollar proportions and has become one of the FDA's most troublesome enforcement responsibilities. As physicians we should be as aware of the dangers of the nontherapeutic use of amphetamines as we are of the abuse of narcotics.—New York State Journal of Medicine.

98TH ANNUAL MEETING

of the

West Virginia State Medical Association

The Greenbrier

AUGUST 26-28, 1965

Plan to Attend — Make Your Reservation . . . Now !

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The President's Page

Your Christmas Gift

At this Christmas season, with another year of medical progress behind us, we survey the results of an election that ironically may also have been the electorate's unwelcomed Christmas gift to medicine. That the Fear Complex was exploited with tremendous success is now history and with it, a liberal tide that could have tragic consequences to our people and our country. As Santagana once said, "Those nations that do not learn the lessons that history has to teach will be condemned to relive them."

Other problems remain, for as the activities of our State Medical Association increase markedly in tempo to keep pace with the demands placed upon us, so also does the drain on its financial resources. To remain alert and active, we must continue the many activities of our organization and aid those charged with the responsibility of action and decisions for our profession.

In this past month in our own State, as you know, the continued and persistent efforts of your State Association's Committee to negotiate with the Compensation Commissioner finally reached the breaking point. Our deep concern is that our patients who are in labor and industry receive the best of medical care and attention plus improvements in rules and regulations and the schedules of patient benefits for physical service. Our fees are also a point of discussion, but persistently the Commissioner has refused to meet with our representatives and has taken a dictatorial stand on the entire problem. Dictatorship may be permissible in Soviet Russia but let us ever strive to uphold the dignity of our profession, the reasonableness of our position and the faith of our forefathers in maintaining that only by mutual personal negotiations can free men hope to endure and preserve our heritage as free men. You still have that choice.

At this Christmas time, Bettye, Bettina, Gregory and Mary Alice join with me in sending along our warmest holiday wishes to you and yours, with the hope that in this New Year each of you may have the best of health and wisdom and that our problems may not be insurmountable.

Albert C. Esposito

Albert C. Esposito, M. D., President

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EDITORIALS

FOREIGN STUDENTS IN UNITED STATES MEDICAL SCHOOLS

Data concerning the admission of students to our medical schools is always of interest, especially since there are more students applying who are residents of the United States than can be accepted. A few months ago the Association of American Medical Colleges issued a datagram concerning the number of foreign students admitted to United States Medical Schools for the 12 academic years 1951-52 through 1962-63. It was calculated that some 1,200 or about 1 per cent of the total of approximately 95,000 admissions during the period represented foreign students.

A foreign student was defined as one who had completed his secondary school education in his home country or some other foreign country (but not in the U. S. or Canada). His collegiate education prior to being admitted to medical school may have been taken all, or in part, in the United States. At the time of entering medical school he was in the United States as an immigrant, or a "displaced person," as an exchange student, or on a student visa or some other type of visa.

Detailed data from 64 medical schools showed that 91 per cent had received part or all of their college level pre-medical education in the United States. Eighty-two per cent had taken the Medical College Admission Test, and 88 per cent had been interviewed personally before admission to medical school.

The data further showed that these students came from over 100 different countries or territories. The geographical regions represented were: the Americas, 28 per cent; Western Pacific, 20 per cent; Eastern Mediterranean, 13 per cent; Southwest Asia, 7 per cent; and Africa 6 per cent.

The matter of financial support was also studied; it came from various sources. Sixty per cent received family financial support, whereas 50 per cent contributed to their own support. Fifteen per cent were aided by United States medical schools; non-refundable grants were supplied to 13 per cent, and tuition exemptions to two per cent. Of all the foreign students encompassed by the 12-year study 57 per cent have been graduated and 29 per cent are still enrolled in United States schools.

There seems to be little doubt that the United States has a real responsibility to help develop leadership in medicine, as in other fields, particularly in those parts of the world whose development has been slower than our own. It is to be expected that these foreign graduates of United States medical schools will serve as ambassadors of good will, and will aid in fostering cordial relations with many countries. Presumably a certain percentage will remain in the United States and will give valuable service to the medical profession. It is believed, however, that the vast majority will return to their native lands, where they doubtless are badly needed. It would appear that by returning to their home-

land they could do the most good for the most people. The education and skills acquired in their training in the United States should stand them in good stead, regardless of whether they engage in the practice of medicine, or in teaching or research in the medical sciences.

NIGHTMARE

In the middle of the night the telephone ring has a dissonant and ominous tone. So you answer and it is the hospital Emergency Room. Your patient John Doe has arrived by car or ambulance with a terrible backache and is demanding your immediate attention. You haven't seen John for years but you feel resasonably sure he can wait until morning for his medical care. There is doubt in your mind, however, concerning his immediate needs and you know you are trapped. It is a situation wherein responsibility cannot legally, morally nor ethically be shifted to the hospital or the nurse. You go to the hospital promptly. The condition is as you suspected. John has had a nagging backache for days. His wife had urged him to come to your office but he delayed in the hope that natural resolution of his troubles would occur. Tonight the backache is worse and John realizes he will be unable to go to work in the morning unless he gets prompt relief—so he goes to the Emergency Room and calls his favorite doctor.

This incident exemplifies the development of the hospital Emergency Room as a place of treatment for all ailments at all times. It has become a substitute for the physician's office because it is always available and services are usually cheaper. It has become a haven for transients, alcoholics, addicts and even your private clientele. Many a physician receives an Emergency Room call from a patient who had been refused an office appointment the same day because no vacancies existed and his complaints were not acute nor disabling. The housewife likes to come to the Emergency Room after the husband is home and the husband chooses to come to the Emergency Room with his head cold because it is inconvenient to wait at the doctor's office. The average Emergency Room has ceased to be a place for the treatment of accidents and medical emergencies; instead, it resembles an army sick call.

Some hospitals employ full-time physicians to care for this type of patient. Hospitals with intern and resident staffs may not find the service to be burdensome. To the non-proprietary hospital without a resident staff, this situation is a *nightmare*. The operation of an Emergency Room is expensive and the collections from the patients will not fulfill the cost. One hospital operates at a loss of $1.60 per patient visit and for the physician the fee for service is usually unpaid. For some reason the Emergency Room patient feels little compulsion to pay either the hospital or physician. It is one of the services he has learned to expect for nothing in this great land of milk and honey.

It may be that the increasing popularity of the Emergency Room represents a new concept in the practice of medicine. The hospital has become a community center for medical care, providing many services that are equally available in the physician's office. Hospital insurance emphasizes the benefits that are prepaid at the hospital but are a personal liability in the doctor's office.

It is possible that the run on the Emergency Room for elective medicine can be controlled through a program of public information and education dispensed by organized medicine and hospitals. Such a program cannot be successful as long as physicians find it convenient to use the Emergency Room as a private office.

It is a problem for discussion between the hospital and the physician. Ground rules will be different for each location. If the present trend continues it will necessitate employment of physicians by hospitals and this will place these institutions squarely in the corporate practice of medicine.

CHRISTMAS AND THE MICROSCOPE

To the recent graduate Osler may be an unfamiliar name. To the graduate of past generations Osler was the father of modern medicine and "Principles and Practice" was the student's Bible. This writer recently found a copy of *Hardwicke's Science-Gossip* (February 1, 1869) and on page 44 is Osler's first publication, "Christmas and the Microscope."

The late Dr. W. Francis, in his "Patter" states: "The Science Gossip contains on p. 44 his (Osler's) first published paper, 'Xmas and the Microscope,' written in 1868. He went out Xmas afternoon, got some water from a frozen spring, examined it under the microscope and described the microscopic plants in it. He had not kept a copy and we only learned about it from the introduction to his catalogue (p. xvii) where he pokes fun at himself fifty years later about his fondness of quotations. 'At the very start of my ink-pot career, a fondness for tags of quotations, this one from Horace, in those days a familiar friend.' Lady Osler had to buy ten vols. of this old hodgepodge at great expense in order to get that one page."

GENERAL NEWS

Council Withdraws Approval Of Compensation Program

The Council of the West Virginia State Medical Association has approved a resolution which withdraws its approval of the rules and regulations of the West Virginia Workmen's Compensation Fund, and further withdraws its approval of patient benefits, i.e., fees for professional services rendered to employees covered under the provisions of Workmen's Compensation Law.

The resolution was adopted unanimously during the fall meeting of the Council which was held at the Daniel Boone Hotel in Charleston on November 8, 1964.

The action was taken after a breakdown in negotiations between the Commissioner and duly constituted committees of the State Medical Association, extending over a period of many months. It was climaxed by the Commissioner's refusal to continue further discussions with the official committee of the State Medical Association. The Commissioner did, however, appoint his own liaison committee which had no official sanction or connection with the committee of the State Medical Association.

The Council recommended that the individual members of the Association continue to render the same quality of medical care as in the past to patients suffering from industrial injuries, and submit to each patient the bill for services rendered to him as a private patient, with the recommendation that the patient submit such statements to the Compensation Commissioner for reimbursement.

In a letter mailed to members of the Association over the signatures of Dr. George R. Callender, Jr., Chairman of the Medical Economics Committee, and Dr. Albert C. Esposito, the President, it was emphasized that the action of the Council in no way interferes with the physician's rights as an individual private practitioner.

The Council further stated that it stands willing to resume discussions with the Commissioner regarding improvement in rules and regulations and the schedule of patient benefits for physicians' services.

The following resolution was approved unanimously by the Council:

WHEREAS, The Compensation Commissioner having been presented recommendations from the West Virginia State Medical Association designed ultimately to result in improvements in the rules and regulations of the Workmen's Compensation Fund, and,

WHEREAS, The West Virginia State Medical Association has further offered the assistance of a liaison committee to assist the Compensation Commissioner in developing improved rules and regulations for the benefit of both recipient of service and for the employer insurers participating in the program, and,

Dr. George R. Callender, Jr., of Charleston, left, chairman of the Medical Economics Committee of the State Medical Association, is shown with Drs. Harry S. Weeks, Jr., of Wheeling, and Kenneth G. MacDonald of Charleston at the meeting of Council in Charleston. Doctors Weeks and MacDonald are chairmen of the Joint Conference and Special Studies sub-committees.

WHEREAS, The Commissioner has disapproved these recommendations and does not feel the need of the assistance of a liaison committee,

BE IT RESOLVED, That the West Virginia State Medical Association hereby withdraws its approval of the rules and regulations of the West Virginia Workmen's Compensation Fund.

WHEREAS, The 1958 revision of the schedule of patient benefits for physician services has been inadequate,

WHEREAS, Insufficient adjustment of these benefits have been made,

WHEREAS, A schedule of patient benefits for physician services has been presented illustrating levels of payments and need for a more comprehensive schedule with time limitations on contractual services,

WHEREAS, A meeting of the Compensation Sub-Committee of the Medical Economics Committee with the Commissioner to discuss and develop a schedule of patient benefits for physician services has been requested,

WHEREAS, This meeting was felt unnecessary by the Commissioner prior to the development of a schedule by the Fund which has been presented to various employer groups for approval, and,

WHEREAS, It was felt that this schedule should not be made available to the West Virginia State Medical Association,

BE IT RESOLVED, That the West Virginia State Medical Association hereby withdraws its approval of the schedule of patient benefits for physician

Dr. Albert C. Esposito of Huntington, third from left, President of the State Medical Association, is shown with other officers at the fall meeting of the Council in Charleston on November 8. They are, left to right, Drs. Richard E. Flood of Weirton, vice president; Seigle W. Parks of Fairmont, president elect; and Charles L. Goodhand of Parkersburg, chairman of the Council.

services as published by the West Virginia Workmen's Compensation Fund,

FURTHER BE IT RESOLVED, That the West Virginia State Medical Association recommends that the members of this Association continue to render the same quality of medical care as in the past to patients sustaining industrial accidents and illnesses and submit to the recipient such fees for service which are considered reasonable compensation,

AND FURTHER BE IT RESOLVED, That the West Virginia State Medical Association stands ready to discuss with the Compensation Commissioner the rules and regulations and the schedule of benefits for physician services at any time in order to develop much needed revisions which the people of West Virginia so desperately need and deserve.

The action of the Council was transmitted in a letter to the Commissioner of the Workmen's Compensation Fund. Copies of the letter also were sent to elected State officials and officers of industrial and labor groups.

Election of Honorary Member

The Council elected the following physician to honorary life membership in the West Virginia State Medical Association:

Society	*Physician*	*Address*
Eastern Panhandle	William A. Wallace	Martinsburg

Interprofessional Code Approved

An "Interprofessional Code of Understanding for Physicians and Pharmacists in West Virginia" was approved unanimously by the Council.

The Code had been approved earlier in the year by the West Virginia State Pharmaceutical Association and it also had been submitted to the Council with the endorsement of the Committee on Medicine and Pharmacy of the State Medical Association. The preamble of the Code reads as follows:

"Because of their roles in caring for the health needs of the public, the physicians and pharmacists of West Virginia are cognizant that with the growing interrelationship of medicine and pharmacy, the two professions are, and will be drawn into steadily increasing association. Now more than ever before, physicians and pharmacists find their professions under close scrutiny by the public and to further serve the health and welfare of the public it is highly important that the professions of medicine and pharmacy be more specifically guided by standards of conduct in their interprofessional activities.

"While the provisions of this Code are not intended to supersede or transcend the laws or principles of ethics governing the individual professions of medicine and pharmacy, it is desired that this Code shall serve to promote and protect the public health and welfare; improve the mutual esteem and practical working relationships of the two health professions and facilitate the care of the patient."

Publication Committee Member Reelected

Dr. William L. Cooke of Charleston was reelected a member of the Publication Committee for the term ending December 31, 1971. Doctor Cooke, who is currently serving as President of the National Tuberculosis Association, has served as a member of the Publication Committee since 1959.

The Publication Committee is composed of the Chairman, Dr. George F. Evans of Clarksburg, who is Editor of *The West Virginia Medical Journal*, and six other members who serve as Associate Editors. The other members are Doctor Cooke and Drs. E. Lyle Gage of Bluefield, Charles L. Goodhand of Parkersburg, D. E. Greeneltch of Wheeling, Edward J. Van Liere of Morgantown and Halvard Wanger of Shepherdstown.

Rehabilitation Program

Dr. Albert C. Esposito presented reports of two meetings held recently for the purpose of discussing the vocational rehabilitation program in West Virginia and the disability determination services program under the Social Security Act.

He reported that there was much interest and active participation by physicians at a joint meeting of the Association's Committee on Rehabilitation and the Advisory Committee to the Division of Vocational Rehabilitation. Doctor Esposito said that members of both groups expressed interest in developing closer liaison between the State agency and members of the medical profession.

The following is a list of those attending the Council meeting on November 8:

Dr. Charles L. Goodhand of Parkersburg, Chairman; Dr. Albert C. Esposito of Huntington, President; Dr. Seigle W. Parks of Fairmont, President Elect; Dr. Richard E. Flood of Weirton, Vice President; Dr. L. J. Pace of Princeton, Councilor-at-Large; and Drs. Charles L. Leonard of Elkins; I. Ewen Taylor of Huntington; Buford W. McNeer of Hinton; Richard W. Corbitt of Parkersburg; William B. Rossman of Charleston; and D. Alene Blake of Oak Hill; and Mr. William H. Lively, Executive Secretary; and Mr. Jerry Gould, Executive Assistant.

The meeting also was attended by Dr. Frank J. Holroyd of Princeton, AMA Delegate; Dr. Thomas G. Reed of Charleston and Dr. D. E. Greeneltch of Wheeling, AMA Alternates; Dr. James S. Klumpp of Huntington, Parliamentarian; Dr. N. H. Dyer of Charleston, State Director of Health; Dr. George R. Callender, Jr., of Charleston, Chairman of the Medical Economics Committee; Dr. Harry S. Weeks, Jr., of Wheeling; Dr. Kenneth G. MacDonald of Charleston; and Mr. Harry Hinton of Chicago, AMA Field Representative.

Jerome P. McDevitt New President Of TB and Health Assn.

Mr. Jerome P. McDevitt of Princeton was elected president of the West Virginia Tuberculosis and Health Association during its 44th annual meeting which was held in Clarksburg, October 7-8.

Dr. Richard V. Lynch, Jr., of Clarksburg, was elected vice president, Mrs. H. D. Rohr of Weston, secretary, and Mr. Winton R. Houck of Charleston, treasurer.

New directors-at-large named to the Board of Directors are Dr. George F. Evans of Clarksburg, Editor of *The Journal*; Mr. Benjamin F. Frye of Wardensville; Mrs. H. H. Cudden of Logan; Doctor Lawless; Mr. E. R. Phelps of Bluefield; Hupp E. Otto of Wheeling; Mrs. E. D. Rothrock of Weirton; Mr. McDevitt; Dr. Leo H. Mynes of Charleston; and Mrs. Viola Wagner of Parkersburg.

Dr. William L. Cooke of Charleston, President of the National Tuberculosis Association, was the speaker at a banquet on Wednesday evening, October 7. His subject was "The Need for the National Tuberculosis Association—A Voluntary Health Agency."

Dr. William L. Cooke Reelected To Publication Committee

Dr. William L. Cooke of Charleston, President of the National Tuberculosis Association, has been reelected a member of the Publication Committee of the West Virginia State Medical Association for a term ending December 31, 1971.

William L. Cooke, M. D.

The Publication Committee is composed of a chairman, who is the Editor of *The West Virginia Medical Journal*, and six other members who serve as associate editors. The Committee is in charge of the publication of *The Journal*, which is the official organ of the West Virginia State Medical Association.

Doctor Cooke is a native of Newport News, Virginia. He was graduated from San Diego State College and received his M.D. degree in 1929 from the Medical College of Virginia.

He served an internship and residency at Charleston General Hospital and is now a trustee of that institution. He had a residency in tuberculosis at Rutherford (Pinecrest) Sanitarium in Beckley, 1930-32.

He is a past president of the Kanawha Medical Society, Anti-Tuberculosis League of Kanawha County, the West Virginia Tuberculosis and Health Association, West Virginia Thoracic Society and the Potomac Chapter of the American College of Chest Physicians.

Doctor Cooke served two terms as a member of the Council of the West Virginia State Medical Association and has been an associate editor of *The Journal* since 1959. He has served as chairman or member of the Association's Tuberculosis Committee for 12 years.

He was medical director of Hillcrest Sanatorium in Charleston for a number of years. He is a past president of the United Fund of the Kanawha Valley and of the Charleston Kiwanis Club. He serves on the advisory board of the local Salvation Army and is a past chairman of the Kanawha-Clay Chapter of the American Red Cross.

Other members of the Publication Committee are Drs. George F. Evans of Clarksburg, Chairman; Halvard Wanger of Shepherdstown; Charles L. Goodhand of Parkersburg; E. Lyle Gage of Bluefield; Edward J. Van Liere of Morgantown; and D. E. Greeneltch of Wheeling.

Change of Address

Members of the West Virginia State Medical Association are requested to notify the headquarters offices promptly concerning any change in address. Notices should be mailed to Box 1031, Charleston, West Virginia 25324.

Auxiliary Fall Conference Held In Beckley, Oct. 20-21

The annual Fall Conference and Board of Directors' meeting of the Woman's Auxiliary to the West Virginia State Medical Association was held at the Beckley Hotel in Beckley, October 20-21.

Mrs. George A. Curry of Morgantown, the president, presided at the business meetings which were attended by state officers, standing committee chairmen, county presidents and presidents elect. Mrs. Pat A. Tuckwiller of Charleston, immediate past president, gave the invocation and pledge of loyalty to open the two-day session.

Report on Chicago Conference

Mrs. Wilson P. Smith of Huntington, the president elect, highlighted the opening session with a review of the 21st Annual Conference of State Presidents, Presidents Elect, National Officers and Committee Chairmen of the Woman's Auxiliary to the American Medical Association which was held in Chicago, October 4-7.

Attending the conference with Mrs. Smith were Mrs. Curry and Mrs. Tuckwiller, who now serves as National Regional Chairman of the Rural Health Committee.

Mrs. Charles W. Merritt of Beckley, president of the Woman's Auxiliary to the Raleigh County Medical Society, extended greetings to those attending the State meeting. The response was given by Mrs. John A. B. Holt of Charleston, third vice president of the State Auxiliary.

The report by Mrs. Curry on her county visitations was followed by reports of the vice presidents, or regional directors. Regional directors reporting were Mrs. Herbert N. Shanes of Grafton, first vice president; Mrs. Holt; and Mrs. Ray M. Kessel of Logan, fourth vice president.

Legislative Developments

Mrs. L. Dale Simmons of Clarksburg, the legislative chairman, discussed recent developments in current or proposed legislation affecting medicine.

Others presenting reports during the meeting included:

Mrs. J. Dennis Kugel, Charleston; Mrs. Robert J. Tchou, Williamson; Mrs. William R. Rice, Dunbar; Mrs. Charles L. Goodhand, Parkersburg; Mrs. Harry E. Beard, Huntington; Mrs. Harry S. Weeks, Jr., Wheeling; Mrs. Rupert W. Powell, Fairmont.

Mrs. Ross P. Daniel, Beckley; Mrs. Clark K. Sleeth, Morgantown; Mrs. Buford W. McNeer, Hinton; Mrs. Joe N. Jarrett, Oak Hill; Mrs. Charles H. Hiles, Wheeling; Mrs. John W. Hash, Charleston; Mrs. Lynwood D. Zinn, Clarksburg; and Mrs. Tuckwiller.

Others attending the meeting were Mrs. M. Bruce Martin of Huntington; Mrs. Earl A. McCowen, Charleston; Mrs. C. B. Buffington, Wheeling; Mrs. Lyle D. Vincent, Parkersburg; Mrs. Byron W. Steele, Mullens; Mrs. Warren D. Elliott, Beckley; and Mrs. James H. Walker, Charleston.

During a business meeting on Wednesday, October 21, the State Auxiliary accepted an invitation to join a new woman's division organized to publicize the work of the S. S. Hope and to help raise funds for its operation through an annual organizational membership of $10.

Doctor Ryan Elected to Board

Dr. Ralph W. Ryan of Morgantown was elected to the Board of Trustees of the National Medical Foundation of Eye Care during the annual meeting held in Chicago on October 18.

Dr. Harold F. Falls of Ann Arbor, Michigan was named president and Dr. J. Spencer Dryden of Washington, D. C., was reelected vice president. Dr. Charles E. Jaeckle of Defiance, Ohio, will serve as secretary during the coming year.

Dr. Halvard Wanger of Shepherd town, left, and Dr. Charles M. Thompson of Philadelphia are shown during the Ninth Annual Potomac-Shenandoah Valley Postgraduate Institute which was held in Martinsburg, October 23-25. Doctor Wanger served as Executive Director of the three-day meeting and Doctor Thompson, Professor of Medicine and Head of the Section on Gastroenterology at Hahnemann Medical College in Philadelphia, was a guest speaker.

In the other picture are four guest speakers. They are Drs. John C. Krantz of Baltimore, Professor and Head of the Department of Pharmacology, University of Maryland School of Medicine; Klaus Thomas of Berlin, Germany, Visiting Psychiatrist, St. Elizabeth's Hospital, Washington, D. C.; Perry S. MacNeal of Philadelphia, Associate Professor of Clinical Medicine, University of Pennsylvania School of Medicine; and Robert J. Johnson of Philadelphia, Professor and Chairman, Department of Anatomy, University of Pennsylvania Graduate School of Medicine.

Dr. George M. Lyon Retiring as Head Of Huntington VA Hospital

Dr. George M. Lyon of Huntington will retire on February 28, 1965, as Director and Chief of Staff of the Huntington VA Hospital.

Doctor Lyon assumed this post on April 1, 1956, after joining the Veterans Administration in 1947 as Special Assistant to the Chief Medical Director for Atomic Medicine and Chief, Radioisotope Division. He became Assistant Chief Medical Director for Research and Education for the VA in 1952.

Among the honors received by Doctor Lyon was a Commendation from Dr. Joseph H. McNinch, Chief Medical Director of the Veterans Administration, and a Meritorious Service Award from Governor W. W. Barron in recognition of his "outstanding contribution to the Veterans Program in the State of West Virginia."

Doctor Lyon is a native of Union City, Pennsylvania, and attended public schools in Sistersville. He also attended Marshall University and was graduated from Denison University. He received his M. D. degree in 1920 from the Johns Hopkins University School of Medicine.

He served an internship and residency in pediatrics at Johns Hopkins Hospital, 1919-21, and practiced in Huntington from 1921 until entering the Medical Corps of the United States Navy in 1942. He was released in 1947 with the rank of Captain.

Doctor Lyon is a member and past president of the Cabell County Medical Society. He is also a member of the West Virginia State Medical Association, Southern Medical Association and the American Medical Assocation.

Spring Congress in Roanoke

The 38th Annual Spring Congress, sponsored by the Gill Memorial Eye, Ear and Throat Hospital, will be held in Roanoke, Virginia, April 5-9, 1965.

Further information may be obtained by writing Dr. E. G. Gill, 711 South Jefferson Street, Roanoke, Virginia.

Medical Meetings, 1964-65

The following is a partial list of national, state and district medical meetings scheduled for 1964-65:

1964

Nov. 29-Dec. 2—AMA Clinical Meeting, Miami Beach.

1965

Jan. 11-13—Medical Licensing Board, Charleston.
March 26-27—National Rural Health Conference, Miami Beach.
April 30-May 2—W. Va. Chapter, AAGP, Wheeling.
May 9-14—Ohio State Medical Assn., Columbus.
May 30-June 2—National TB Assn., Chicago.
June 20-24—AMA Annual Meeting, New York.
Aug. 26-28—W. Va. State Medical Association, The Greenbrier, White Sulphur Springs.
Sept. 18-26—Pennsylvania Medical Society, Atlantic City.
Oct. 22-24—Potomac-Shenandoah Valley PG Institute, Martinsburg.
Nov. 1-4—Southern Medical, Houston, Texas.

Infectious Syphilis Has Increased 124 Per Cent Since 1957

Infectious syphilis has increased 124 per cent in West Virginia since 1957 despite modern methods of prevention and treatment.

Writing in his weekly State of the State's Health, State Director of Health Dr. N. H. Dyer noted that 12 new cases of primary and secondary syphilis recorded during September set a record for any month in recent years and equals the total of new cases reported for any three-month period in the past decade.

In West Virginia approximately two-thirds of all venereal disease is uncovered among persons under 25. During the past year, a 60 per cent increase has occurred in the geographic distribution of early syphilis cases. No one section of the state, race, social or economic class is responsible; the problem cuts through all strata of society.

These needs must be met to develop more effective control over the situation in our state:

Prompt and accurate reporting by private laboratories and physicians.

Funds to employ and train additional investigators. There are only five to cover the entire state.

An intensive educational effort aimed at the problem must be developed and carried out.

Trained health educators are needed to work with mass media, parent groups, other community organizations, and local schools. More attention must be given to developing adequate units of instruction on venereal disease for the schools.

No Statutory Authority

In another issue of the publication, Doctor Dyer discussed the State Health Department's role in non-medical birth control clinic activities. He pointed out that "no statutory authority expressed nor implied in our state has come to our attention granting the State Board of Health authority to engage in birth control activities unless there is a factor of health associated."

He also noted that the State Department of Health has had conflicting policy statements from the U. S. Department of Health, Education and Welfare on using federal funds for such clinics.

Doctor Dyer indicated that, considering the very meager state appropriation for maternal and child health care and that only limited health needs of many mothers and children can be met with the services now provided through federal health grants, at this time, "to solve the dilemma of what present health services for needy mothers and children could be denied to finance non-medical birth control clinic activities seems unrealistic and impractical."

Need a New Auto Emblem?

A supply of auto emblems, bearing the insignia of the West Virginia State Medical Association, is kept on hand at all times at the headquarters offices in Charleston. The price of each emblem is $3.25 postpaid.

61 Physicians Licensed by MLB To Practice in State

The Medical Licensing Board licensed 61 physicians, 45 by examination and 16 by reciprocity, at a meeting held at The Capitol in Charleston, July 13-15, 1964. The following physicians were licensed by direct examination:

Baker, Mary Rebecca, Baltimore, Md.
Bliffen, Gary, Compton, California
Bonnesen, Charles Henry, III, Wheeling
Boonsue, Aarom, Mullens
Brassine, William Florent, Clarksburg
Bryant, James Lee, II, Belle
Craycraft, Larry Burns, Kenova
Dobbs, Frederick Henry, II, Charleston
Donahoe, Dorval Hendrix, Kenova

Fowler, Donald Richard, Parkersburg
Fullmer, John Lee, Morgantown
Gasataya, Julian Delina, Lumberport
Gilbert, Gary Gene, Baltimore, Md.
Gustke, Robert Fred, Morgantown
Hash, Volney Wade, Jr., Columbus, Ohio
Hunter, Ralph, Parkersburg
Johnson, Randall Edward, U. S. Air Force Academy
Jordan, Jon Lyle, Charlottesville, Virginia

Josef, Ernesto Jacinto, Ripley
Kandzari, Stanley Joseph, Granville
Kopp, James Emidio, Clarksburg
Ladwig, Charles Lloyd, Jr., Houston, Texas
Larese, Ricci Joe, Portsmouth, Virginia
McBride, John William, South Bend, Indiana
McMurray, John Thomas, Wheeling
Mouser, Lowell Thomas, Morgantown
Naum, George Phillip, Wheeling

Perez, Jose Amado, Charleston
Pushkin, Jack, Morgantown
Ramos, Pedro Alfredo, Man
Richmond, Richard Dale, Morgantown
Sanford, Okey Homer, Charlton Heights
Smith, Barry Malcolm, Charles Town
Smith, Charles Elton, II, Charleston
Smith, David Earl, Bluefield
Steele, Ida May Hogshead, South Charleston

Thompson, Richard Melville, Beckley
Tompkins, Grover Robert, Charleston
Turner, Charles Edward, Huntington
Vaughan, John William, St. Albans
Wallace, David Earl, Madison
Warvariv, Eugene, Beckley
Weisberg, Edward Saul, Charleston
Wolford, Keith Harlow, Romney
Young, Robert Eugene, Montgomery

The following is a list of the physicians who were licensed by reciprocity:

Austin, John Hallock, Wheeling
Gardner, Robert Joseph, Fairmont
Hille, Richard Roy, Marietta, Ohio
Keefer, Frank Jay, Bellaire, Ohio
Kiczales, Adolphe Charles, Martinsburg
Liepack, Jerry Glenn, Moundsville
Lull, Clifford Bell, Jr., Frederick, Maryland
Nelson, Charles William, Jr., Beckley

Owen, Kenneth Eugene, Marietta, Ohio
Pfister, Lois Estelle, South Charleston
Reed, Joseph Blount, Burlington
Schmidt, Roland Eugene, Morgantown
Small, James Thomas, Jr., Westernport, Md.
Steele, James Lebreet, South Charleston
Vanston, Gerald Edward, Huntington
Whitley, Ebb. Keister, Jr., Iaeger

Medical Certification Film Now Available

The Division of Vital Statistics of the State Department of Health now has available a 25-minute color film entitled "Medical Certification of the Causes of Death" for showing at meetings of component medical societies.

The film presents for physicians the principles to be followed in completing the medical certification on the death certificate.

State Director of Health Dr. N. H. Dyer said a physician from the department staff would attend the meetings at which the film is shown to discuss the importance of recording complete and accurate information on death certificates.

Requests for the film should be directed to the Division of Vital Statistics, State Department of Health, Charleston, West Virginia 25305.

Ophthalmology Section Accepting Papers

The Section on Ophthalmology of the Southern Medical Association is now accepting papers to be considered for presentation before the annual meeting in Houston, Texas, November 1-4, 1965.

The title and a brief extract of 75 words or less should be sent to the Secretary, Dr. George S. Ellis, 812 Maison Blanche Builidng, New Orleans, Louisiana 70116. The deadline is May 15.

Officers and Board Members Elected By W. Va. Nurses Association

Miss Nancy Martin of Moundsville, an instructor in Medical-Surgical Nursing at the Ohio Valley General Hospital in Wheeling, was elected first vice president of the West Virginia Nurses Association at its 57th annual meeting at Oglebay Park in Wheeling, October 21-23.

Mrs. Ardenia M. Tully of South Charleston was reelected secretary and Mrs. Delsia Copeland of Beckley and Miss Audrey Windemuth of Morgantown were named to the organization's Board of Directors.

Mrs. Josephine Fultz of Clarksburg, the president, will serve the second year of a two-year term. Miss Cecilia Coyne of Bridgeport, Ohio, is the second vice president and Mrs. Mabel Strong of Glen Dale, Marshall County, treasurer.

PG Course In Pediatrics

A postgraduate course on the "Pediatric Aspects of Surgery in Childhood" will be presented by the University of Cincinnati College of Medicine in Cincinnati, May 24-25, 1965.

Registration is limited to 50 physicians and the fee is $50. Further information may be obtained by writing to Dr. William Schubert, The Children's Hospital, Cincinnati, Ohio 45229.

Outwardly calm...but what goes on inside?

Appearances on the outside do not necessarily suggest what goes on inside. This is particularly true of the ulcer patient, who may appear jolly and unruffled to his neighbors, but presents to you the classic symptoms: organic and functional disorders of the G.I. tract, associated with anxiety and tension.

Consider, when you see him next, the value of PATHILON® SEQUELS® with Phenobarbital, which provides sustained anticholinergic protection from spasm and pain in the target areas, as well as sustained phenobarbital action against triggering anxiety. The controlled release of the active ingredients in the SEQUELS® formulation means protective medication day and night.

Effective in peptic ulcer, intestinal colic, ileitis, esophageal spasm, spastic colon, alcohol-induced G.I. upsets, gastric hypermotility and anxiety neurosis with G.I. symptoms. Should be used as adjunct to other measures.

Side Effects (due to tridihexethyl chloride): dry mouth, blurring of vision, constipation.

Contraindications: urinary bladder neck obstruction; glaucoma; obstructive congenital anomalies of the gastrointestinal tract; pyloric obstruction; congenital megacolon; and stenosing gastric or duodenal ulcer with significant gastric retention.

Also available, without phenobarbital, as PATHILON® Tridihexethyl chloride SEQUELS® 75 mg.

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Each capsule contains: Tridihexethyl chloride, 75 mg., and phenobarbital, 45 mg.

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279-4

INDEX TO VOLUME LX

THE WEST VIRGINIA MEDICAL JOURNAL — 1964

A

Acne, Etiological Factors in—Robert E. English, M. D., and Joseph A. Witkowski, M. D. July 178
Allergy, Occupational and Household, Due to Inhalants—Macy I Levine, M. D. May 126
Anderson, Robert J., M. D.—Air Pollution, Respiratory Disease and the NTA Nov. 332
Aneurysms of the Carotids and Their Branches, Treatment of Berry—E. Lyle Gage, M. D. Feb. 29
Angiography, Changing Concepts of—Joseph L. Curry, M. D., Willard J. Howland, Jr., M. D., Andrew K. Butler, M. D., Charles T. Lenton, Jr., M. D., and Zoltan Szalontay, M. D. Apr. 87
Athlete, Safeguarding the Health of the—Kenneth S. Clarke, Ph.D. Oct. 286

B

Beckner, William F., M. D.—The History of E.E.N.T. Practice in West Virginia Apr. 100
Benshoff, Arthur M., M. D., and George E. Farrell, M. D.—Primary Varicella Pneumonia Aug. 203
Bereston, Eugene S., M. D.—Contact Dermatitis in the Home and in Industry Mar. 66
Berry Aneurysms of the Carotids and Their Branches, Treatment of—E. Lyle Gage, M. D. Feb. 29
Blood Replacement, Massive—Norman W. B. Craythorne, M. D. June 154
Bowie, W. Scott, A.B., E. Lyle Gage, Jr., A.B., E. Lyle Gage, M. D., and Russell V. Lucas, Jr., M. D.—Brain Abscess in Cyanotic Health Disease May 113
Bradley, Robert L., M. D.—Postoperative Leukocytosis Nov. 338
Brain Abscess in Cyanotic Heart Disease—W. Scott Bowie, A.B., E. Lyle Gage, Jr., A.B., E. Lyle Gage, M. D., and Russell V. Lucas, Jr., M. D. May 113
Bronchitis, Chronic—Leslie N. Gay, M. D. Oct. 282
Butler, Andrew K., M. D., Charles T. Lenton, Jr., M. D., Zoltan Szalontay, M. D., Joseph L. Curry, M. D., and Willard J. Howland, Jr., M. D.—Changing Concepts of Angiography Apr. 87

C

Callender, George R., Jr., M. D.—A Dire Necessity for West Virginia: 'Adequate Minimum Medical Care' Jan. 14
Callender, George R., Jr., M. D.—A Special Report by the Medical Economics Committee Mar. 74
Carcinoma, Intra-Epithelial, of the Cervix and Pregnancy—Joseph C. Parker, M. D. May 120
Carotids and Their Branches, Treatment of Berry Aneurysms of the—E. Lyle Gage, M. D. Feb. 29
Cephalalgia, Histaminic, The Diagnosis and Treatment of—Robert E. Ryan, M. D. Jan. 5
Cerebrovascular Disease, Hyperuricemia and Gout—John S. Meyer, M. D., George P. Kypros, M. D., and John Gilroy, M. D. June 150
Cervix, Intra-Epithelial Carcinoma of the, and Pregnancy—Joseph C. Parker, M. D. May 120
Chronic Bronchitis—Leslie N. Gay, M. D. Oct. 282
Circadian Rhythm and Medicine—Edward J. Van Liere, M. D. Nov. 340
Clarke, Kenneth S., Ph.D.—Safeguarding the Health of the Athlete Oct. 286
Coffey, F. L., M. D., G. F. Woelfel, M. D., and H. Carl Wasson, Jr., M. D.—Islet Cell Tumors of the Pancreas Dec. 351
Colitis, Chronic Ulcerative, The Role of the Surgeon in the Management of—Edward S. Judd, M. D. Mar. 61
Commencement Exercises, Pre-: West Virginia University School of Medicine—Hon. Okey L. Patteson Sept. 258
Community Hospital Experience in the Surgical Management of the Elderly Patient—Edward C. Voss, Jr., M. D. Feb. 35
Contact Dermatitis in the Home and in Industry—Eugene S. Bereston, M. D. Mar. 66
Coronary Heart Disease, Current Management of—James W. Woods, M. D. Apr. 97
Craythorne, Norman W. B., M. D.—Massive Blood Replacement June 154
Curry, Joseph L., M. D., Willard J. Howland, Jr., M. D., Andrew K. Butler, M. D., Charles T. Lenton, Jr., M. D., and Zoltan Szalontay, M. D.—Changing Concepts of Angiography Apr. 87

D

Dermatitis, Contact, in the Home and in Industry—Eugene S. Bereston, M. D. Mar. 66
Diabetes Mellitus, An Evaluation of the Glucose Skin Test in the Diagnosis of—Frank E. Medford, M. D. Sept. 255
Diagnosis and Treatment of Histaminic Cephalalgia, The—Robert E. Ryan, M. D. Jan. 5
Diospyrobezoar—George E. Farrell, M. D., and Robert G. Shirey, M. D. May 123
Dominguez, Fernando, M. D., Charles C. McKay, M. D., and Hans Dransfeld, M. D.—Small Series of Lymphograms with Clinical Applications Aug. 199
Dransfeld, Hans, M. D., Fernando Dominguez, M. D., and Charles C. McKay, M. D.—Small Series of Lymphograms with Clinical Applications Aug. 199
Duodenal Ulcer and the Success of Therapy—J. C. Handelsman, M. D. Apr. 92
Duodenal Ulcer, Changing Concepts in Surgical Treatment of—Edward S. Judd, M. D. Jan. 1

E

Economics Committee, Medical, A Special Report by the—George R. Callender, Jr., M. D. Mar. 74
E.E.N.T. Practice in West Virginia, The History of—William F. Beckner, M. D. Apr. 100
Elderly Patient, Community Hospital Experience in the Surgical Treatment of—Edward C. Voss, Jr., M. D. Feb. 35
Ellison, A. B. Curry, M. D., William C. Stewart, M. D., and Alfred K. Pfister, M. D.—Hypoglycemia Following Sulfonylurea Therapy Dec. 356
English, Robert E., M. D., and Joseph A. Witkowski, M. D.—Etiological Factors in Acne July 178
Etiological Factors in Acne—Robert E. English, M. D., and Joseph A. Witkowski, M. D. July 178
Evaluation of the Glucose Skin Test in the Diagnosis of Diabetes Mellitus, An—Frank E. Medford, M. D. Sept. 255

F

Farrell, George E., M. D., and Arthur M. Benshoff, M. D.—Primary Varicella Pneumonia Aug. 203
Farrell, George E., M. D., and Robert G. Shirey, M. D.—Diospyrobezoar May 123

G

Gage, E. Lyle, M. D., Russell V. Lucas, Jr., M. D., W. Scott Bowie, A.B., and E. Lyle Gage, Jr., A.B.—Brain Abscess in Cyanotic Heart Disease May 113
Gage, E. Lyle, M. D.—Treatment of Berry Aneurysms of the Carotids and Their Branches Feb. 29
Gage, E. Lyle, Jr., A.B., E. Lyle Gage, M. D., Russell V. Lucas, Jr., M. D., and W. Scott Bowie, A.B.—Brain Abscess in Cyanotic Heart Disease May 113
Gay, Leslie N., M. D.—Chronic Bronchitis Oct. 282
Gilroy, John, M. D., John S. Meyer, M. D., and George P. Kypros, M. D.—Hyperuricemia, Gout and Cerebrovascular Disease June 150
Glucose Skin Test, An Evaluation of the, in the Diagnosis of Diabetes Mellitus—Frank E. Medford, M. D. Sept. 255
Goodhand, Charles L., M. D.—Medical Progress, Its Problems and Challenge (Presidential Address) Oct. 277
Goshen, Charles E., M. D.—Recent Developments in the Federal Government's Narcotic Program Jan. 9
Gout, Hyperuricemia, and Cerebrovascular Disease—John S. Meyer, M. D., George P. Kypros, M. D., and John Gilroy, M. D. June 150

H

Hamilton, Mrs. Melinda—Dr. Jesse Bennett—Pioneer Physician (1769-1842) Feb. 42
Handelsman, J. C., M. D.—Duodenal Ulcer and the Success of Therapy Apr. 92
Hash, Mrs. John W.—Mental Health Planning in West Virginia June 157
Heart Disease, Cyanotic, Brain Abscess in—W. Scott Bowie, A.B., E. Lyle Gage, Jr., A.B., E. Lyle Gage, M. D., and Russell V. Lucas, Jr., M. D. May 113
Histaminic Cephalalgia, The Diagnosis and Treatment of—Robert E. Ryan, M. D. Jan. 5
History of E.E.N.T. Practice in West Virginia, The—William F. Beckner, M. D. Apr. 100

Hospital, Community, Experience in the Surgical Management of the Elderly Patient—Edward C. Voss, Jr., M. D. Feb. 35
Howland, Willard, Jr., M. D., Andrew K. Butler, M. D., Charles T. Lenton, Jr., M. D., Zoltan Szalontay, M. D., and Joseph L. Curry, M. D.—Changing Concepts of Angiography Apr. 87
Hyperuricemia, Gout and Cerebrovascular Disease—John S. Meyer, M. D., George P. Kypros, M. D., and John Gilroy, M. D. June 150
Hypoglycemia Following Sulfonylurea Therapy—A. B. Curry Ellison, M. D., William C. Stewart, M. D., and Alfred K. Pfister, M. D. Dec. 356

I

Inhalants, Occupational and Household Allergy Due to—Macy I. Levine, M. D. May 126
Intra-Epithelial Carcinoma of the Cervix and Pregnancy—Joseph C. Parker, M. D. May 120
Islet Cell Tumors of the Pancreas—H. Carl Wasson, Jr., M. D., F. L. Coffey, M. D., and G. F. Woelfel, M. D. Dec. 351

J

Judd, Edward S., M. D.—Changing Concepts in Surgical Treatment of Duodenal Ulcer Jan. 1
Judd, Edward S., M. D.—The Role of the Surgeon in the Management of Chronic Ulcerative Colitis Mar. 61

K

Kanawha Medical Society's Welfare Evaluation Committee, A Special Report by the Nov. 325
Kypros, George P., M. D., John Gilroy, M. D., and John S. Meyer, M. D.—Hyperuricemia, Gout and Cerebrovascular Disease June 150

L

Lenton, Charles T., Jr., M. D., Zoltan Szalontay, M. D., Joseph L. Curry, M. D., Willard J. Howland, Jr., M. D., and Andrew K. Butler, M. D.—Changing Concepts of Angiography Apr. 87
Leukocytosis, Postoperative—Robert L. Bradley, M. D. Nov. 338
Levine, Macy I., M. D.—Occupational and Household Allergy Due to Inhalants May 126
Life, The Matrix of—W. D. Snively, M. D. Feb. 44
Lucas, Russell V., Jr., M. D., W. Scott Bowie, A.B., E. Lyle Gage, Jr., A.B., and E. Lyle Gage, M.D.—Brain Abscess in Cyanotic Heart Disease May 113
Lymphograms, Small Series of, With Clinical Applications—Fernando Dominguez, M. D., Charles C. McKay, M. D., and Hans Dransfeld, M. D. Aug. 199

M

Massive Blood Replacement—Norman W. B. Craythorne, M. D. June 154
Matrix of Life, The—W. D. Snively, M. D. Feb. 44
McKay, Charles C., M. D., Hans Dransfeld, M. D., and Fernando Dominguez, M. D.—Small Series of Lymphograms With Clinical Applications Aug. 199
Medford, Frank E., M. D.—An Evaluation of the Glucose Skin Test in the Diagnosis of Diabetes Mellitus Sept. 255
Medical Care', 'Adequate Minimum: A Dire Necessity for West Virginia—George R. Callender, Jr., M. D. Jan. 14
Medical Progress, Its Problems and Challenge (Presidential Address)—Charles L. Goodhand, M. D. Oct. 277
Medicine in Retrospect—Norman A. Welch, M. D. Sept. 262
Mental Health Planning in West Virginia—Mrs. John W. Hash June 157
Mesothelioma, Pleural (Report of Two Cases: One Benign and One Malignant)—Victor M. Napoli, M. D. July 173
Meyer, John S., M. D., George P. Kypros, M. D., and John Gilroy, M. D.—Hyperuricemia, Gout and Cerebrovascular Disease June 150

N

Napoli, Victor M., M. D.—Pleural Mesothelioma (Report of Two Cases: One Benign and One Malignant) July 173
Narcotic Program, Recent Developments in the Federal Government's—Charles E. Goshen, M. D. Jan. 9

O

Occupational and Household Allergy Due to Inhalants—Macy I. Levine, M. D. May 126

P

Pancreas, Islet Cell Tumors of the—H. Carl Wasson, Jr., M. D., F. L. Coffey, M. D., and G. F. Woelfel, M. D. Dec. 351
Parker, Joseph C., M. D.—Intra-Epithelial Carcinoma of the Cervix and Pregnancy May 120
Parrish, Henry M., M. D., Dr. P. H.—Survey of Snakebites in West Virginia June 143
Patteson, Hon. Okey L.—Pre-Commencement Exercises: West Virginia University School of Medicine Sept. 258
Pfister, Alfred K., M. D., A. B. Curry Ellison, M. D., and William C. Stewart, M. D.—Hypoglycemia Following Sulfonylurea Therapy Dec. 356
Physician, Pioneer—Dr. Jesse Bennett (1769-1842)—Mrs. Melinda Hamilton Feb. 42
Pleural Mesothelioma (Report of Two Cases: One Benign and One Malignant)—Victor M. Napoli, M. D. July 173
Pneumonia, Primary Varicella—George E. Farrell, M. D., and Arthur M. Benshoff, M. D. Aug. 203
Pollution, Air, Respiratory Disease and the NTA—Robert J. Anderson, M. D. Nov. 332
Postoperative Leukocytosis—Robert J. Bradley, M. D. Nov. 338
Practicing Physician, The, and Community Psychiatric Efforts—William F. Sheeley, M. D. Aug. 205
Pregnancy, and Intra-Epithelial Carcinoma of the Cervix—Joseph C. Parker, M. D. May 120
Primary Varicella Pneumonia—George E. Farrell, M. D., and Arthur M. Benshoff, M. D. Aug. 203
Psychiatric Efforts, Community, and The Practicing Physician—William F. Sheeley, M. D. Aug. 205

R

Recent Developments in the Federal Government's Narcotic Program—Charles E. Goshen, M. D. Jan. 9
Report of the School of Medicine, West Virginia University—Clark K. Sleeth, M. D. Dec. 360
Respiratory Disease, Air Pollution, and the NTA—Robert J. Anderson, M. D. Nov. 332
Role of the Surgeon in the Management of Chronic Ulcerative Colitis, The—Edward S. Judd, M. D. Mar. 61
Ryan, Robert E., M. D.—The Diagnosis and Treatment of Histaminic Cephalalgia Jan. 5

S

Safeguarding the Health of the Athlete—Kenneth S. Clarke, Ph.D. Oct. 286
School of Medicine, West Virginia University, Report of the—Clark K. Sleeth, M. D. Dec. 360
Shakespeare, A Doctor Looks at—Bernard W. Wilkinson, M. D. July 182
Sheeley, William F., M. D.—The Practicing Physician and Community Psychiatric Efforts Aug. 205
Shirey, Robert G., M. D., and George E. Farrell, M. D.—Diospyrobezoar May 123
Sleeth, Clark K., M. D.—Report of the School of Medicine, West Virginia University Dec. 360
Small Series of Lymphograms with Clinical Applications—Fernando Dominguez, M. D., Charles C. McKay, M. D., and Hans Dransfeld, M. D. Aug. 199
Snakebites, Survey of, in West Virginia—Henry M. Parrish, M. D., Dr. P. H. June 143
Snively, W. D., M. D.—The Matrix of Life Feb. 44
Special Report by The Kanawha Medical Society's Welfare Evaluation Committee, A Nov. 325
Special Report by the Medical Economics Committee, A—George R. Callender, Jr., M. D. Mar. 74
Stewart, William C., M. D., Alfred K. Pfister, M. D., and A. B. Curry Ellison, M. D.—Hypoglycemia Following Sulfonylurea Therapy Dec. 356
Surgical Management of the Elderly Patient, Community Hospital Experience in the—Edward C. Voss, Jr., M. D. Feb. 35
Survey of Snakebites in West Virginia—Henry M. Parrish, M. D., Dr. P. H. June 143
Szalontay, Zoltan, M. D., Joseph L. Curry, M. D., Willard J. Howland, Jr., M. D., Andrew K. Butler, M. D., and Charles T. Lenton, Jr., M. D.—Changing Concepts of Angiography Apr. 87

T

Treatment of Berry Aneurysms of the Carotids and Their Branches—E. Lyle Gage, M. D. Feb. 29
Tumors, Islet Cell of the Pancreas—H. Carl Wasson, Jr., M. D., F. L. Coffey, M. D., and G. F. Woelfel, M. D. Dec. 351

U

Ulcer, Duodenal, and the Success of Therapy—J. C. Handelsman, M. D. Apr. 92
Ulcer, Duodenal, Changing Concepts in Surgical Treatment of—Edward S. Judd, M. D. Jan. 1

V

Van Liere, Edward J., M. D.—Circadian Rhythm and Medicine Nov. 340
Voss, Edward C., Jr., M. D.—Community Hospital Experience in the Surgical Management of the Elderly Patient Feb. 35

W

Wasson, H. Carl, Jr., M. D., F. L. Coffey, M. D., and G. F. Woelfel, M. D.—Islet Cell Tumors of the Pancreas Dec. 351
Welch, Norman A., M. D.—Medicine in Retrospect Sept. 262
West Virginia University School of Medicine: Pre-Commencement Exercises—Hon. Okey L. Patteson Sept. 258
Wilkinson, Bernard W., M. D.—A Doctor Looks at Shakespeare July 182
Witkowski, Joseph A., M. D., and Robert E. English, M. D.—Etiological Factors in Acne July 178
Woelfel, G. F., M. D., H. Carl Wasson, Jr., M. D., and F. L. Coffey, M. D.—Islet Cell Tumors of the Pancreas Dec. 351
Woods, James W., M. D.—Current Management of Coronary Heart Disease Apr. 97

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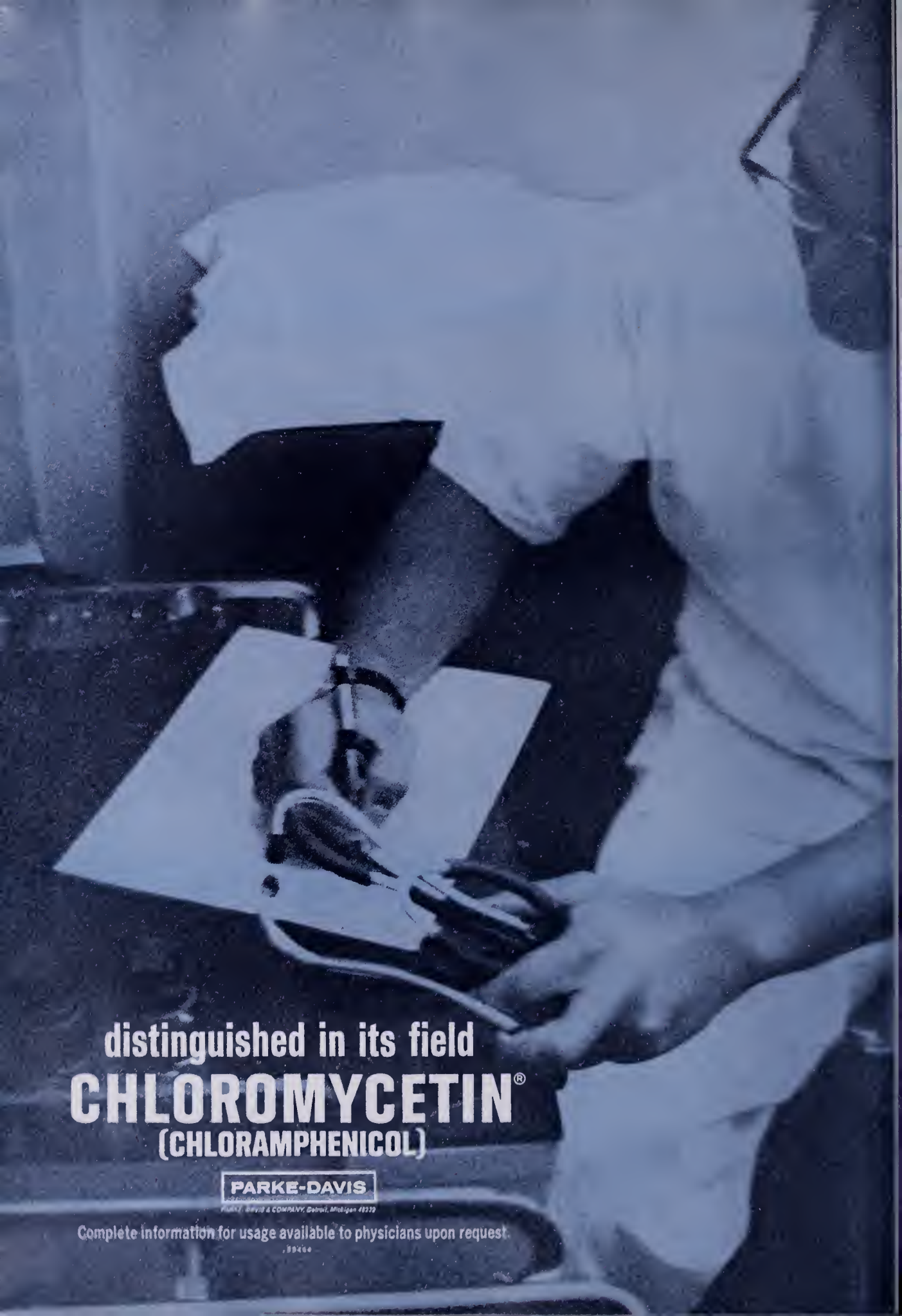
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